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ABSTRACT

Volume III of a three-volume guide to school-based and school-linked health centers, this document notes that communities that wish to continue existing school-based health clinics or to start new ones may need to explore federal support for health center operations. This manual identifies federal health, education, and social programs which support the kinds of services provided by school health centers. Some of these programs described cover a broad array of health services; other cover specific types of services; still others support demonstration or model projects. For each of these programs, the manual identifies the program's purpose and structure, who may be served with the funds, what services they may receive, major programmatic and administrative requirements for funded service providers, application procedures, and a federal contact person for additional information. The 15 chapters in the manual focus on: (1) the flow of federal funds; (2) Health Care Block Grants; (3) Title V: Maternal and Child Health Services Block Grant; (4) Preventive Health and Health Services Block Grant; (5) Substance Abuse Prevention and Treatment Block Grant; (6) Community Mental Health Services Block Grant; (7) Medicaid; (8) Section 330: Community Health Centers; (9) Drug-Free Schools and Communities - state grants; (10) Title X: Family Planning Services; (11) Women, Infants, and Children (WIC) Program; (12) Social Services Block Grant; (13) Child Care and Development Block Grant; (14) direct grants for innovative, demonstration or special projects; and (15) three state case studies (New Jersey, New Mexico, and California). The manual focuses on requirements found in the federal law. Appendices include: (1) a list of acronyms; (2) a list of federal agencies with responsibility for adolescent services; (3) Medicaid federal financial participation rates by state; and (4) state contacts for selected federal programs. (NB)

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THE SUPPORT CENTER
FOR SCHOOL-BASED
AND SCHOOL-LINKED
HEALTH CARE

A Guide to School-Based and School-Linked Health Centers

VOLUME III:

Potential Sources of Federal Support for School-Based and School-Linked Health Services

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CPO is a nonprofit organization that works to increase the opportunities for and abilities of youth to make healthy decisions about sexuality. Since 1980, CPO has provided information, education and advocacy to youth-serving agencies and professionals, policymakers and the media.

Support Center for School-based and School-linked Health Care/CPO

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The Support Center/CPO provides information, technical assistance, training, policy analysis and advocacy to assist in establishing school-based and school-linked health centers (SBHCs) and in enhancing their operations.

Public Affairs Program/CPO

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The Public Affairs Program/CPO assists policymakers and advocates by providing information, consultation and publications on: adolescent health issues, state and federal legislation, model programs, policy options and the impact of public policy decisions on adolescents. The department also provides support at all stages of the legislative process, including assistance with testimony and identification of expert witnesses.

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INTRODUCTION

Over the last decade the number of school-based and school-linked health centers (SBHCs) has increased dramatically. The handful of pioneering school health centers operating in the early 1980's has grown to approximately 500 operating throughout the country today. Sponsored primarily by community health clinics, public health departments, hospitals and medical schools, and, to a lesser degree, by school systems and other nonprofit and community agencies, the SBHC has become an important means to provide children and adolescents with access to primary care.

Many of the early school health centers were model demonstration programs supported by private foundations. The growing number of SBHCs has been matched by their declining reliance on private foundations for support and increasing reliance on public sources of funding. In particular, state and local public dollars currently provide about half of the funding for school-based health centers, and over two-thirds of the funds for school-linked health centers.[1]

With state and local governments trimming their budgets, communities that wish to continue existing SBHCs or to start new ones may need to explore the potential for securing federal support for health center operations. Those that do will find a maze of programs, each with its own requirements regarding eligibility, services, and administration.

This manual is intended as a starting point for those trying to tap into federal funds. It identifies federal health, education and social programs which support the kinds of services provided by school health centers. Some of these programs cover a broad array of health services; others cover specific types of services; still others support demonstration or model projects. For each of these programs, the manual identifies the program's purpose and structure, who may be served with the funds, what services they may receive, major programmatic and administrative requirements for funded service providers, application procedures (when possible) and a federal contact person for additional information.

This manual does not, however, identify every requirement for each program. First, some federal programs have so many requirements that they cannot all be included. Second, many financial, administrative and reporting requirements apply generally to recipients of federal funds and are found in the general regulations of the administering agency. Once a decision is made to explore any particular funding source, the relevant federal office should be contacted for further information. Application materials will spell out in detail programmatic, financial, administrative, reporting, and other requirements.

Finally, in many of the programs described, states play a critical role in distribution of the funds, so that each state's own laws and procedures also determine how the funds are spent, who may receive them, how to apply and so on. This manual focuses on requirements found in the federal law. Appendix D lists program-by-program state contacts who can explain the requirements of the program in your state.

SBHCs in search of federal support should also consult two additional sources. First, the *Catalog of Federal Domestic Assistance*, compiled by the Office of Management and Budget and the General Services Administration, is published every year in June, with a supplementary update in December. In addition to descriptions of federal assistance programs it includes general information on how to apply for federal funds and identifies regional and local federal agency offices. It can be purchased from the Government Printing Office and may be found in public libraries.[2] Second, in 1992 the United States Department of Health and Human Services published *Healthy Schools: A Directory of Federal Programs and Activities Related to Health Promotion Through the Schools*, which was compiled under the auspices of the Federal Interagency Ad Hoc Committee on Health Promotion Through the Schools. It includes brief descriptions of federal programs, activities and clearinghouses related to schools and health. To obtain a copy, contact the National Center for Health Information and Communication of the Office of Disease Prevention and Health 1 1 1Promotion.[3]

SBHCs seeking federal support should also remember that direct funding of health center services is not the only way federal programs can support the health centers' operations. Indeed, many SBHCs may conclude that they cannot meet all the requirements of a particular program. Furthermore, in all federal programs, funding has become extremely tight. SBHCs trying to obtain funding from a new source will compete with those who have traditionally received funds from that source, entities with whom the administering agency is familiar and feels comfortable funding.

Given these barriers to obtaining direct funding from new sources, SBHCs should explore the possibility of entering formal arrangements with service providers that do receive these funds. In such arrangements, staff from the agency that receives the funding provide some of their services on site at the SBHC. The agency may also be in a position to manage the administrative paperwork and serve as a financial conduit. SBHCs should also consider how they can use the funds they have to collaborate with another organization in a win-win arrangement that stretches the dollars for both organizations. For instance, if a SBHC has a small amount of dollars for a case manager, it might want to look for an organization in a similar situation; perhaps they can pool their dollars and share a case manager.[4] Finally, SBHCs should remember that many federal programs which do not provide direct funding for services do provide technical assistance, training opportunities and clearinghouse services, which can enhance health center operations.

The likelihood of SBHCs tapping into new funding sources, whether directly or indirectly, might well be enhanced if SBHCs adopt a number of strategies suggested by Dr. Claire Brindis of the Institute for Health Policy Studies, University of California, San Francisco. First, SBHCs can use their own utilization data to justify SBHC access to particular funding sources to policymakers. For instance, if utilization data reveal that a significant proportion of students receive mental health services from SBHCs, presenting this data could help persuade policymakers that SBHCs ought to receive mental health funds. Second, SBHCs might develop state and regional networks to share information with each other about funding sources. For instance, SBHCs who overcome barriers and successfully tap into Medicaid could share how they did it with other SBHCs. A coalition to collectively articulate SBHC needs to policymakers and advocate for SBHC-friendly policies would also be advantageous.

Within the next few years the outlook for federal support of SBHCs could change dramatically. A bill sponsored in 1992 by Sen. Edward Kennedy of Massachusetts and in 1993 by Rep. Maxine Waters of California would create the Comprehensive Services for Youth Act, which would provide funds for a variety of local, state and national activities related to youth services. Almost half of the funds would go to community partnerships for coordination and delivery of comprehensive education, health and social services to children and youth at school-based, school-linked and community-based sites. SBHCs can monitor the status of this potentially very important source of funds by contacting their members of Congress. Tthese legislative efforts are complemented by administrative efforts on the part of the Department of Health and Human Services, whose Bureau of Primary Health Care is seeking special funding for school-based health services.

Health care reform could also drastically alter the federal health funds landscape. It is not known which of the programs described in this manual will survive after implementation of health care reform. Nor is it certain that services provided by SBHCs will be covered in the Administration proposal. In particular, if health care reform focuses on providing the bulk of health services through managed care entities, SBHCs could find themselves effectively, if inadvertently, cut out of the program; SBHCs have traditionally had difficulty obtaining reimbursement for services provided to students who are also enrolled in private managed care programs. On the optimistic side, indications are that the Clinton Administration is supportive of SBHCs. Indeed, during President Clinton's tenure as Governor of Arkansas, SBHCs were developed throughout the state, under the leadership of Dr. Joycelyn Elders, Director of the Arkansas Department of Health and President Clinton's designee for Surgeon General.

As health care reform moves through the political process supporters will need to help policymakers understand the important role SBHCs play in overcoming the non-financial barriers, as well as the financial barriers, to health services for children and adolescents and to insure that mechanisms for compensating SBHCs are part of a reformed health care system.

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[1] C. Waszak and S. Neidell, *School-Based and School-Linked Clinics: Update 1991*, Center for Population Options: Washington, DC, 1991. This is the source for all data regarding the current share of SBHCs' budgets provided by various sources.

[2] The *Catalog of Federal Domestic Assistance* costs $42; it is available from the Superintendent of Documents, Government Printing Office, Washington, DC, 20402, (202) 783-3238.

[3] This agency can be reached at P.O. Box 1133, Washington, DC, 20013-1133, (800) 336-4797 or (301) 565-4167. There is a $5 handling fee.

[4] The author is indebted to Dr. Claire Brindis of the Institute for Health Policy Studies at the University of California, San Francisco, for this suggestion.

CHAPTER ONE:
THE FLOW OF FEDERAL FUNDS

Federal funds which support services can follow a number of different routes to service providers, with states playing a number of roles in the process. For instance, in a block grant program, such as the Maternal and Child Health Services Block Grant or the Preventive Health and Health Services Block Grant, funds are provided to states for a number of related purposes, and the states are given broad discretion to determine the specific uses for the funds and the mechanisms for distributing funds to service providers. Some block grant programs require that states match federal block grant funds with state funds in a specified ratio.

Other programs, such as Medicaid and the Supplemental Food Program for Women, Infants, and Children (WIC), are operated jointly by the federal and state governments. In these programs, the states may have less discretion over how the funds will be spent than in block grant programs, but state laws and procedures still have a big impact on whether a particular service provider can receive the funds. In these jointly- operated programs, states may also have to provide some state dollars in order to receive the federal funds.

In other federal programs, such as the Community and Migrant Health Center program and the Maternal and Child Health Special Projects of Regional and National Significance program (SPRANS), funds go directly from the federal government to the service provider. Even in these programs, the federal law may involve state officials at some points in the decision-making process. In addition, Executive Order 12372, "Intergovernmental Review of Federal Programs," gives state officials the option to review and comment on requests by agencies and individuals in their state for federal funding under a large number of federal programs.[1]

Some programs target benefits to low-income individuals, or entirely limit eligibilty for benefits to those with low income. Federal programs frequently (although not always) define low income in terms of the federal poverty guidelines. When originally devised, these guidelines were intended to reflect the amount of income a household with a given number of individuals would need to provide a basic, minimally sufficient standard of living. With the exception of special guidelines for Alaska and Hawaii, the poverty guidelines are used nationally. Each year, they are adjusted according to changes in the Consumer Price Index to account for inflation.

Although many critics have questioned whether the guidelines accurately reflect the income needed to maintain a basic, decent standard of living, they are nevertheless widely used as standards in government programs. For instance, eligibility may be restricted to those with incomes at or below the poverty line. Alternatively, individuals whose income is at or below a particular percentage of the poverty line may be eligible for discounted services. The table below gives the 1993 poverty guidelines applicable to all states except Alaska and Hawaii, as well as various percentages of the federal poverty guidelines relevant to programs described in this manual.

TABLE 1: 1993 Federal Poverty Guidelines: Annual Income

Household Size	Poverty Level	133% of Poverty	185% of Poverty	200% of Poverty	250% of Poverty
1	6,970	9,270	12,895	13,940	17,425
2	9,430	12,542	17,446	18,860	23,575
3	11,890	15,814	21,997	23,780	29,725
4	14,350	19,086	26,548	28,700	35,875
5	16,810	22,357	31,099	33,620	42,025
6[1]	19,270	25,629	35,650	38,540	48,175

[1] To calculate the poverty level for larger households, add 2,460 for each additional member.

1When a state selects a federal program as one for which it wants to review applications coming from private or public entities in the state, applicants must contact an official designated as the "Single State Point of Contact." A list of these officials is included in the *Catalog of Federal Domestic Assistance*.

CHAPTER TWO:
THE HEALTH CARE BLOCK GRANTS: COMMON ELEMENTS

There are four federal health care block grants: the Maternal and Child Health Services Block Grant, the Preventive Health and Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant and the Community and Mental Health Services Block Grant. Although each is used to support very different types of health care services, they have a number of elements in common. This section describes those common elements and individual descriptions of each of these block grants follow.

States use these block grant funds to support health care services and activities. The funds may also be used for related planning, administration, education and evaluation activities. With some exceptions these block grant funds may not be used for inpatient services; purchase, construction or improvement of land, buildings and other facilities (except for minor remodeling); or purchase of major medical equipment. With the exception of the Maternal and Child Health Services Block Grant, only public or nonprofit private entities can receive financial assistance under the health care block grants.

States receive these block grant funds by submitting annual applications. Although the specific requirements for annual applications vary from program to program, in general the application must include a plan which describes how the state intends to use the block grant funds and how it will meet the programmatic requirements of the block grant law. During development of the state plan, the states must make it available for public review and comment, a process in which SBHCs should consider participating. For the most part, federal law allows states to determine how to distribute block grant funds among potential recipients. States are also free to determine what kinds of applications and documentation are required to receive funds.

At the end of the grant year, each state must also submit an annual report. Again, the required content of the annual reports varies from block grant to block grant, but generally the annual reports must describe the actual use of the funds, the individuals served by the funds and the types of services provided. Federal law requires that the states make their annual block grant reports available to the public upon request. SBHCs can obtain copies to see how their state has used its health services block grant funds in the recent past.

CHAPTER THREE:

TITLE V: MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

Currently the most important source of federal funds for SBHCs is Title V of the Social Security Act, also called the Maternal and Child Health Services Block Grant, which generally supports health services for children and adolescents.[1] Many SBHCs tap into Title V funds, which, on average, provide almost one-fifth of SBHCs' operating dollars.

Congress created this block grant in 1981 by consolidating eight programs related to the health of children, pregnant women and mothers. The Maternal and Child Health Bureau of the Public Health Service of the U.S. Department of Health and Human Services oversees the program, which granted over 500 million dollars to the states in FY 1993. The amount of funds allotted to each state depends on the share of funds the state received in FY 1981 under the programs which were consolidated into the block grant and on the proportion of low-income children in the United States who live in the state. States are required to match every four federal dollars received from Title V with three dollars of their own.

In creating this block grant, Congress gave the states broad authority to determine how to spend the funds, within the context of the law's broadly stated purposes. These purposes include assuring pregnant women, mothers and children, especially those with limited income, access to quality preventive, primary, prenatal, delivery and postpartum care; reducing infant mortality, preventable childhood diseases and handicapping conditions; providing rehabilitation services to disabled children; and providing family-centered, community-based, coordinated care to children with special health needs.[2] A 1989 amendment requires states to spend at least 30 percent of their Title V funds for preventive and primary care for children and at least 30 percent on community-based care for children with special health needs.(CSHN)[3]

With some exceptions, the federal law requires that a state's health agency manage the Title V program. Typically, there are two different divisions, one overseeing funds for maternal, infant, and children's preventive and primary care and the other overseeing funds for children with special health needs.

States may use Title V funds to provide a broad range of maternal and child health services, with few limits as to the types of health services the block grant funds may support. Among the health providers who receive Title V funds are state and local health departments, community health centers, hospitals and physicians, as well as SBHCs. Since 1989, amendments to Title V have steered states in the direction of using the funds to **develop systems** of maternal and child health care, with the result that a somewhat greater proportion of the funds has gone to statewide planning activities.

Although the federal law emphasizes the particular need to serve low-income children and pregnant women, it does not require that all recipients of services provided with Title V funds be low-income. The law does require that health services supported by Title V funds provide services free of charge to women and children with incomes below the official poverty line; states may impose charges for Title V services on those with higher incomes if the charges are based on a public sliding fee scale. The Title V mandate to serve children includes adolescents. Neither the statute nor the regulations specify an upper age limit for the children who may be served with Title V, and some states have used Title V to provide services to "children" as old as age 21.

The federal law does not specify any other requirements for health services provided with Title V funds. It directs states to develop ways to assure the quality of Title V services, including guidelines for the frequency, content, referral and follow-up of Title V services.

Some states use Title V funds to support directly SBHCs. SBHCs also receive indirect Title V support when they are sponsored by public health departments or other recipients of Title V funds.

Although currently many SBHCs receive funding through Title V, a 1989 survey found that only eighteen states were using their Title V dollars to support SBHCs, and the majority of these devoted less than 5 percent of these dollars to SBHCs.[4] Federal funding of SBHCs through Title V could get a boost from S. 632, a bill introduced in 1992 by Sen. David Durenberger of Minnesota. S. 632 would explicitly include school-based health services as an authorized use of Title V funds and increase the funding authorization for Title V. However, S. 632 would not require that any Title V funds go to SBHCs.

See Appendix D for your state contact who can provide information on whether your state would support your SBHC with Title V funds, on how to apply, and on how to comment on the state application as it is developed.

Federal contact for more information about Title V:

Brad Perry
Program Services, Development, and Information Branch
Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3163

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[1] The law is found at Title 42 of the United States Code, sections 701 709, which is cited as 42 U.S.C. §§ 701-709. The United States Code is the publication in which statutes enacted by Congress are found, organized by subject matter. There are no specific regulations for Title V but regulations applicable to a number of block grants apply. These regulations are at Title 45 of the Code of Federal Regulations, Part 96, which is cited as 45 C.F.R. Part 96 The Code of Federal Regulations is the publication in which regulations issued by the executive branch are published, organized by subject matter.

[2] A 1986 amendment to Title V replaced the term "crippled children" with the term "children with special health needs."

[3] The amendment grew out of concern that too great a proportion of the funds was being spent on preventing infant mortality, so that children over the age of one were getting short shrift. In some circumstances states can have this requirement waived by the Secretary of Health and Human Services. This amendment reflects Congress's desire in recent years to provide more direction for the spending of Title V funds.

[4] M. McManus, R. Kelly, P. Newacheck and J. Gephart, The Role of Title V Maternal and Child Health Programs Assuring Access to Health Services for Adolescents, McManus Health Policy, Inc.: Washington, DC (undated).

CHAPTER FOUR:

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

The Preventive Health and Health Services Block Grant (PHHS) is another block grant that provides funds that states may use for an array of health services and health-related activities.[1] SBHCs have not reported receiving PHHS funds, but in 1992 Congress made significant changes in the program which could redirect some of the states' use of the funds in the future.

Like Title V, Congress created this block grant in 1981 by consolidating several loosely related public health and preventive health grant programs. The Centers for Disease Control and Prevention of the Public Health Service of the Department of Health and Human Services oversees the program, which will grant over 140 million dollars to states in FY 1993. The amount of funds allotted to each state depends primarily on the share of funds the state received in FY 1981 under the programs consolidated into the block grant.

When Congress first created the PHHS block grant, the law authorized use of the funds for a number of specific health projects which mirrored several of the consolidated programs. It also more generally permitted use of PHHS funds for community-based demonstration projects that provide comprehensive preventive health services to defined populations; risk reduction and health education programs; and public health services.[2] In 1992, most of these provisions were replaced with a directive that PHHS funds be used for health activities that are aimed at achieving specific health status objectives for the United States population. These health objectives were announced by the Secretary of Health and Human Services and detailed in a report called *Healthy People 2000: National Disease Prevention and Health Promotion Objectives for the Nation*. *Healthy People 2000* lays out a national preventive health agenda.[3] Its development took three years, and involved health professionals, public agencies, private organizations and private citizens. It identifies three broad public health goals: increasing the healthy life span of Americans; reducing health disparities among Americans; and assuring universal access to preventive health services. These are further developed in 300 objectives organized in 22 priority areas. The priority areas which may be of special interest to SBHCs are: alcohol and other drugs; tobacco; mental health; violent behavior; educational and community-based programs; family planning; maternal and infant health; HIV infection and other sexually transmitted diseases; immunization and infectious disease; physical activity and fitness; nutrition; unintentional injuries; and clinical preventive services.[4]

As noted above, the 1992 amendments retained references to some of the specific types of activities authorized under the older version of the law. States are required to spend a specified portion of their PHHS funds to provide services to victims of sexual offenses and to support activities to prevent sexual offenses.[5] The federal law contains no limits on who may be served with PHHS block grant funds. It requires that agencies and organizations that receive block grant funds adhere to a state-developed system for protecting the confidentiality of patient records. The federal law does not specify any other requirements for health services provided with PHHS block grant funds. States are responsible for developing reasonable criteria to evaluate the performance of block grant recipients.

To receive PHHS block grant funds, a state must have a Preventive Health Advisory Committee, which includes representatives of local health departments and the general public, and may include representatives from community-based organizations, public health schools and recipients of block grant funds. The Advisory Committee assists in the development and implementation of the state PHHS plan and holds public hearings on it.

Although the 1992 amendments aim at focusing PHHS block grant funds on achievement of a national health agenda and SBHCs services are directed at many elements of that agenda, it is not clear whether any of the PHHS block grant funds will actually be available to SBHCs in the near future. According to the agency which oversees the PHHS block grant, at the encouragement of the federal government, many of the states have tied up their PHHS block grant funds in long-term obligations to specific preventive health and public health services and activities. It could take several years before many changes are evident in states' use of PHHS block grant funds.

See Appendix D for your state contact who can provide information on whether your state would support your SBHC with PHHS funds, on how to apply, and on how to comment on the state application as it is developed.

Federal contact for more information about the Preventive Health and Health Services Block Grant:

Mr. Joseph Webb
Office for Surveillance and Analysis
National Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control
Public Health Service
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 488-5299

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[1] The law is found at 42 U.S.C. §§ 300w - 300w 8; provisions regarding the administration of block grants at 31 U.S.C. §§ 7301-7305 apply. Regulations found at 45 C.F.R. Part 96 (which are applicable to a number of block grants) also apply.

[2] When the PHHS block grant was first enacted, specifically enumerated projects included school or community based fluoridation programs; comprehensive programs to deter smoking and alcohol consumption by children and adolescents; projects to prevent rape and other sexual offenses and assist victims; programs to detect and treat hypertension, elevated cholesterol, uterine cancer and breast cancer; rodent control programs; immunization; development of emergency medical systems; and establishment of home health agencies where they are unavailable.

[3] The full report, which is 700 pages, costs $42 and is available from the Government Printing Office, Washington, DC, 20402, (202) 783-3238. A summary, which includes all of the national health objectives, is available from the National Center for Health Information and Communication, Office of Disease Prevention and Health Promotion, P.O. Box 1133, Washington, DC 20013-1133, (800) 336-4797 or (301) 565-4167. There is $4 handling fee for the summary.

[4] Other *Healthy People 2000* priority areas include occupational safety; environmental health; food and drug safety; oral health; heart disease and stroke; cancer; diabetes and chronic disabling conditions; and surveillance and data systems.

[5] The law also specifically permits use of PHHS funds to support rodent control programs, fluoridation projects and planning for emergency medical services.

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CHAPTER FIVE:

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

About three-fifths of SBHCs have substance abuse programs. SBHCs may be able to obtain support for these services through another block grant for specific health services, the Substance Abuse Prevention and Treatment Block Grant (SAPT).[1]

The SAPT block grant has its origins in 1981 when Congress created the Alcohol and Drug Abuse and Mental Health Services Block Grant (ADMS) by consolidating several substance abuse and mental health categorical grant programs. In 1992, in a reorganization of the agency responsible for the ADMS block grant, Congress split the ADMS block grant into two distinct block grants, the SAPT Block Grant and the Community Mental Health Services Block Grant (described below). In 1993, the Department of Health and Human Services issued interim regulations, scheduled to be finalized by January 1, 1994, which provide further direction to the states' use of SAPT block grant funds.

The Substance Abuse and Mental Health Services Administration in the Public Health Service of the Department of Health and Human Services oversees the SAPT block grant, which will provide over one billion dollars to the states in FY 1993. Each state's share of the funds is determined by a complicated formula that takes into account the state's taxable resources, the relative cost of substance abuse services in the state compared to other states, the age breakdown of the state's population, and the extent to which the state's adults 18 - 24 year olds live in urban settings.

States may use SAPT funds to support services, programs, and activities designed to prevent or treat alcohol and other drug abuse. The federal law contains several provisions directing how a state's total allotment is split. At least 35 percent must be used for prevention and treatment activities related to alcohol abuse and at least 35 percent must be used for activities related to other drug abuse. In fiscal years 1993 and 1994 the state must use at least five percent of its grant to increase the availability of treatment services that meet the special needs of pregnant women and women with children, and in subsequent years must at least maintain this level of funding.[2] A state may use no more than five percent of its allotment to administer the block grant.

Of particular interest to SBHCs is the provision requiring that each state use at least 20 percent of its SAPT grant funds for primary prevention programs. Under the SAPT block grant law, primary prevention is distinct from treatment or even early intervention. It is defined as services, programs and activities for individuals not in need of treatment for substance abuse, which either educate or counsel these individuals about substance abuse, or provide them with activities which reduce the risk that they will abuse alcohol or other drugs.[3] The law requires that states give priority to programs using community-based strategies which are targeted at populations who are at high risk for substance abuse.

The interim regulations further delineate requirements for this primary prevention set-aside. The regulations require that each state develop a comprehensive prevention program which incorporates an array of strategies provided in a variety of settings. The primary prevention program must include activities and services aimed at the general population, as well as services targeted at high-risk subgroups. The regulations specifically permit the state to provide primary prevention services through nonprofit private entities. Some of the suggested primary prevention strategies include: programs that educate participants about substance abuse and help them develop the skills to resist abusing alcohol, drugs or tobacco; broad-based dissemination of information to the public through media campaigns, health fairs, information clearinghouses and similar activities; alternative activities for targeted populations which exclude substance abuse, such as drug-free parties, youth leadership programs and drop-in centers; and programs which identify individuals who have used drugs and assess whether their behavior can be changed through education.

The federal law imposes no income or other limits on who may be served with SAPT block grant funds, but does impose a number of requirements on service providers that receive block grant funds.

- Programs receiving grant funds for treatment services must give priority to pregnant women for admission to treatment services; when they cannot admit a pregnant woman seeking treatment they must refer her to the state.
- Programs receiving grant funds for treatment services must, either directly or through arrangements with another public or nonprofit provider, provide patients receiving substance abuse treatment with tuberculosis testing and treatment.
- Grant recipients must have provisions for continuing education of their staff.
- Grant recipients must adhere to a state-developed system for protecting the confidentiality of patient records.

To assess and promote the quality of treatment services in the state, each state must provide for independent peer review of treatment services provided by agencies and organizations receiving block grant funds; at least five percent of programs receiving funds must be reviewed each year.[4]

When Congress created the SAPT block grant in 1992, it also linked a state's eligibility for the block grant funds to adoption of a number of specific substance abuse policies. For instance, to receive block grant funds a state must prohibit the sale of tobacco to minors (and enforce the prohibition); improve its process for referral of individuals to appropriate substance abuse treatment; and coordinate prevention and treatment services with other health, education, employment and social services, and the criminal justice/corrections system. The state must also provide continuing education for the staff of facilities and programs which receive SAPT block grant funds and meet special obligations to pregnant women who need substance abuse treatment and to individuals in need of treatment for intravenous drug abuse.

See Appendix D for your state contact who can provide information on whether your state would support your SBHC with SAPT funds, on how to apply, and on how to comment on the state application as it is developed.

Federal contact for more information about the Substance Abuse Prevention and Treatment Block Grant:

George Kanuck
Division of State Programs
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockwall II Building, 10th Floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3820

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[1] The law is found at 42 U.S.C. §§ 300x-21 – 300x-64; provisions regarding the administration of block grants at 31 U.S.C. §§ 7301-7305 may also apply. Regulations specific to the SAPT block grant were published on March 31, 1993 as an interim final rule, and are found at 58 Fed. Reg. 17062-17080. Regulations found at 45 C.F.R. Part 96, which are applicable to a number of block grants, also apply.

[2] Interim regulations require that services funded with this set-aside for pregnant women and women with dependent children must provide for prenatal and other primary medical care; gender-specific substance abuse treatment; therapeutic intervention for any of the children's developmental problems and neglect/abuse issues; and case management services. The five percent set-aside can be waived if a state shows that it already has sufficient treatment resources available for pregnant women and women with dependent children.

[3] This is a definite change from the forerunner ADMS block grant, which required that states use 20 percent of their block grant funds for prevention and early intervention activities. The distinction between primary prevention and early intervention does not apply to other federal substance abuse programs.

[4] Additional requirements apply to programs that receive block grant funds and treat IV drug users. These programs must engage in certain outreach activities and must notify the State when they have reached 90 percent of their capacity to admit patients.

CHAPTER SIX:

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

About four-fifths of SBHCs provide mental health and psychosocial counseling. To the extent that these services are provided to children and adolescents with a mental illness, SBHCs may be able to obtain support for these services — most likely indirectly — through the Community Mental Health Services Block Grant (CMHS).[1]

The CMHS block grant is the second half of the old Alcohol and Drug and Mental Health Services Block Grant. The Substance Abuse and Mental Health Services Administration in the Public Health Service of the Department of Health and Human Services oversees the CMHS block grant. This block grant will provide 265 million dollars to the states in FY 1993. Each state's share of the funds is determined by a formula that takes into account the state's taxable resources, the relative cost of community mental health services in the state compared to other states and the age breakdown of the state's population.

The purpose of the CMHS block grant is to reduce unnecessary hospitalization of the mentally ill by supporting community-based mental health care. To be eligible for block grant funds, the state must develop a plan for providing an organized system of community-based mental health services for children with a serious emotional disturbance and adults with a serious mental illness. The block grant funds are used to implement the plan. A state may use no more than five percent of its grant to administer the block grant.

The CMHS block grant imposes special obligations on the states regarding services for children, which recognizes the multiple needs of many mentally ill children. The mental health services plan must provide for an integrated system of services for them, which is linked to a defined geographic area and includes education, substance abuse, health, juvenile and social services, in addition to mental health care. The CMHS block grant funds, however, can only be spent on providing the community-based mental health services portion of the integrated system. In FY 1993 and 1994, each state must use at least ten percent of its grant to increase the level of funding for services for mentally ill children, and in subsequent years the level of funding must at least equal the amount spent in FY 1994.[2]

The CMHS block grant also requires states to insure that case management services are provided to mentally ill individuals who receive substantial amounts of public funds or services. Each state also must have a program of outreach to and services for mentally ill people who are homeless.

To receive services supported by block grant funds, the law requires that mentally ill children have a "serious emotional disturbance" and adults have a "serious mental illness;" the law directed the Secretary of Health and Human Services to define these terms. Regulations which became final on May 20, 1993 define a child with a serious emotional disturbance as:

- a person up to the age of 18
- who currently has or in the past year has had
- a diagnosable mental, behavioral or emotional disorder, other than substance abuse or developmental disorders (unless these occur with another diagnosable disorder)
- which substantially interferes with or limits the child's role or functioning in family, school or community activities.[3]

Also included are children who otherwise fit this definition but who lack the functional impairment because they are receiving treatment or support services. A similar definition applies to adults.

Under the forerunner ADMS block grant, only community mental health centers could receive the mental health portion of the block grant funds. Under the CMHS block grant, eligible providers have been expanded to "appropriate qualified community programs, which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs and mental-health primary consumer-directed programs."

To qualify as a community health center, the law imposes a number of specific requirements. Community mental health centers must provide prompt, accessible, high-quality services to the individuals in a geographic area, without regard to their ability to pay and in a way that insures continuity of care. And they must provide a broad range of services: outpatient services, including specialized care for children, the elderly, the seriously mentally ill and persons recently discharged from inpatient mental health treatment; 24-hour-a-day emergency care; day treatment, partial hospitalization or psychosocial rehabilitation services; and screening to determine the appropriateness of an individual's admission to state mental health facilities.

The law does not include standards that other community mental health programs must meet to be eligible for CMHS funds, and to date the Substance Abuse and Mental Health Services Administration has not issued guidelines that define or limit which mental health programs may qualify for CMHS block grant funds. It may well be up to each state to determine how comprehensive a program's mental health services must be to qualify for CMHS funds.

As is the case for SAPT funds, CMHS grant recipients must adhere to a state-developed system for protecting the confidentiality of patient records. To assess and promote the quality of treatment services in the state, each state must provide for independent peer review of treatment services provided by recipients of block grant funds; at least five percent of programs receiving funds must be reviewed each year.

To be eligible for funds, states must have a mental health planning council which reviews the state mental health services plan and makes recommendations for modifications, assesses the adequacy of mental health services in the state and serves as an advocate for the mentally ill. The council must include representatives of a variety of specified state agencies that provide mental health, vocational, social and other services to the mentally ill; public and private entities that are involved with mental health services; adults with mental illnesses; and the families of children or adults with mental illnesses. A majority of council members must be individuals who neither work for the state nor provide mental health services.

Even with the expansion of entities eligible to receive block grant funds for mental health services, SBHCs may have difficulty accessing them directly. States may require that funded mental health programs provide more comprehensive mental health services than SBHCs can provide, and SBHCs may simply not serve enough children and adolescents with serious emotional disturbances to warrant a grant. But if direct receipt of CMHS funds is not possible, SBHCs may well be able to receive indirect assistance through a formal arrangement with a community mental health center or other funded program, in which staff from the funded program provide services on-site at the SBHC. Because of the community-based nature of SBHCs and their acceptance by students, they may have the capacity to serve as an effective element in a community-based system of mental health care that aims at promoting the capacity of the mentally ill to function in the community.

See Appendix D for your state contact who can provide information on whether your state would support your SBHC with CMHS funds, on how to apply, and on how to comment on the state application as it is developed.

Federal contact for more information about the Community Mental Health Services Block Grant:

Peggy Gilliam, Acting Chief of State Planning
  and Systems Development
Division of State and Community Systems Development
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockwall II Building, Suite 501
5600 Fishers Lane
Rockville, MD 20857
(301) 443-0001

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[1] The law is found at 42 U.S.C. §§ 300x–300x-9 and 300x-51–300x-64; provisions regarding the administration of block grants at 31 U.S.C. §§ 7301–7305 may also apply. Regulations found at 45 C.F.R. Part 96, which are applicable to a number of block grants, also apply.

[2] The set-aside for children's services may be waived if the state can show that it is already providing an adequate level of comprehensive community mental health services for children.

[3] Diagnosable mental, behavioral and emotional disorders are those that are found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) of the American Psychiatric Association. To be covered by the CMHS block grant, the definition requires that the child's disorder be "of sufficient duration to meet diagnostic criteria specified within DSM-III-R." In addition to excluding substance abuse and developmental disorders, the definition excludes DSM-III-R "V" codes, which are conditions that cannot be traced to a mental disorder but for which people receive treatment, for instance, "academic problems," "childhood or adolescent antisocial behavior" or "parent-child problem."

CHAPTER SEVEN: MEDICAID

Medicaid, Title XIX of the Social Security Act, is the single largest source of federal funds for health services for children and adolescents.[1] The Medicaid program pays for health services provided to low-income individuals who meet its eligibility criteria. Although SBHCs serve large numbers of low-income students, Medicaid provides on average less than ten percent of SBHCs' operating budgets. Programmatic and administrative features of the Medicaid program have hindered SBHCs' efforts to tap into Medicaid funds. If these can be overcome, Medicaid is an attractive source of funds for SBHCs because it pays for preventive health services.

The importance of Medicaid to SBHCs is greater than its potential for serving as a direct source of funding for SBHC services. Several other federal health care programs, for instance the Community Health Centers Program and the Title X Family Planning Program, require that service providers receiving funds from these programs seek reimbursement for services provided to Medicaid-eligible clients. Hence, the capacity to tap into Medicaid funds can affect a SBHC's ability to secure other federal funds.

Medicaid is operated jointly by the federal and state governments. Under Medicaid, the state pays health care providers a fee for providing services to individuals who are eligible for Medicaid. The federal government then reimburses the state for a portion of these costs, from 50 percent to 83 percent, depending on the state's per capita income.[2] Medicaid is an entitlement program; every individual who meets the eligibility requirements is entitled to receive Medicaid benefits.

At the federal level, the Medicaid Bureau in the Health Care Financing Administration of the Department of Health and Human Services oversees the Medicaid program. In FY 1993, it is projected that federal Medicaid grants to the states will exceed 80 billion dollars, serving almost 33 million people. About one-quarter of Medicaid recipients are children aged six to 20, who account for about ten percent of Medicaid dollars spent.[3] Each state must designate a state agency that is responsible for the state's Medicaid program.[4] The state Medicaid agency oversees the implementation of the state Medicaid plan, the document that describes in detail the state's Medicaid program.

There is enormous variation in Medicaid programs from state to state. Within the context of a complex federal framework, each state makes its own rules regarding beneficiary and provider eligibility, covered services, rates of provider reimbursement and operational procedures. As a result, for a SBHC to determine how to tap into Medicaid and whether overcoming the administrative difficulties are worth the SBHC's effort, the health center must work with state Medicaid personnel. The following is a roadmap to assist in that process.

Federal Medicaid law requires that the state plan provide Medicaid eligibility for certain groups of people. These groups include recipients of Aid to Families with Dependent Children (AFDC); recipients of Supplemental Security Income (SSI), a cash assistance program for poor people who are elderly, blind or disabled;[5] pregnant women poor enough to meet AFDC income and other financial assets criteria; and pregnant women and children up to age six with a family income that is at or below 133 percent of the federal poverty line. In addition, mandatory coverage of all children whose family income is at or below 100 percent of the federal poverty line is being phased-in. All such children born after September 30, 1983 are eligible for Medicaid; by the year 2002 all children up to the age of 19 who live in poverty will be covered.[6]

The federal law also permits states to cover certain other groups of individuals, including, for instance, pregnant women and infants with family incomes of up to 185 percent of the poverty line; and certain "medically needy" individuals whose medical expenses reduce their available income and financial assets to no more than 133 percent of the state's AFDC payments.[7]

Covered services — that is, services for which providers can be reimbursed by the Medicaid program and states can be reimbursed by the federal government — are also divided into mandatory and optional components. Among the services states must cover[8] are

- hospital services (both inpatient and outpatient);
- physicians' services;
- services provided by nurse-midwives and certified pediatric or family nurse practitioners who are practicing within the scope of state law;
- laboratory and X-ray services;
- family planning services and supplies;
- prenatal care;
- for individuals under 21, early and periodic screening, diagnosis and treatment services (the EPSDT program, which is described in greater detail below);
- and the services of rural and federally qualified health centers (FQHCs).[9]

Among some two dozen specified services that states can provide at their option, are

- dental care;
- pediatric services;
- optometrist services and eyeglasses;
- clinic services provided by or under the direction of a physician;
- prescription drugs;
- speech, hearing, and language disorder services;
- case management services; and
- diagnostic, screening, preventive or rehabilitative services provided by a licensed health care practitioner. (It is under this optional service that some states provide outpatient mental health care.)

Under their Medicaid programs states can — and do — go beyond the mandatory and optional coverage requirements of the federal law and pay for medical services or cover other groups of people that are not included in the federal law. They cannot, however, receive federal reimbursement for the costs of providing these additional services or covering these additional people.

Since 1981, Congress has made changes in the Medicaid program which permit states to experiment with innovative health care delivery and reimbursement systems that promise to contain health care costs. As a result, the majority of states provide services to a combined total of approximately two and half million Medicaid-eligible individuals through enrollment in health maintenance organizations or other managed care plans. Furthermore, President Clinton has promised to facilitate the federal waiver process which permits states to experiment with Medicaid managed care systems. These systems are problematic for SBHCs because Medicaid reimbursable services provided to a Medicaid-eligible student covered through a managed care provider must be arranged through that provider.

In addition to determining who is eligible for Medicaid services and what services are covered, states determine which providers can receive reimbursement for covered services provided to Medicaid-eligible individuals. Providers must meet state-established criteria, standards and qualifications to be certified as Medicaid providers. Each state also determines the maximum amount it will pay for each service. Providers must agree to accept the state rate as full payment for the service.[10]

Of potential special importance to SBHCs is EPSDT, the Early and Periodic Screening, Diagnosis, and Treatment Program for Medicaid-eligible individuals under the age of 21.[11] As noted above, each state must have an EPSDT component in its Medicaid program. Amendments made to the federal EPSDT provision in 1989 have essentially transformed it into a comprehensive, preventive health care program for children and adolescents eligible for Medicaid.

Under the EPSDT program, children enrolled in the program receive regular health screenings and medically necessary diagnostic and treatment services for conditions found through the screenings. Each state must establish medically reasonable periodicity schedules to determine when EPSDT screening occurs; in addition, enrolled children are eligible for screening services whenever medically necessary because of signs that the child has developed a new health problem since the last periodic screening, or because an old health problem has worsened since that time. EPSDT screenings include the taking of a comprehensive health and developmental history; a comprehensive, unclothed physical exam; immunizations; laboratory tests; and health education. Children enrolled in the EPSDT program are eligible to receive vision, hearing and dental services, and all other medically necessary diagnostic and treatment services which can be reimbursed by the federal government under the Medicaid program, regardless of whether the state otherwise includes the service in its Medicaid plan.

While all children who are eligible for Medicaid are eligible for enrollment in the EPSDT program, enrollment is voluntary. States are responsible for conducting outreach to Medicaid-eligible families with children to inform them of EPSDT benefits (which include assistance with scheduling and transportation to EPSDT appointments) and to encourage them to enroll.

SBHCs have a number of potential roles in the EPSDT program, for which they can receive funding from Medicaid. At a minimum, SBHCs can contract with their state to assist in conducting outreach to Medicaid-eligible families and enrolling children in EPSDT. They may also provide screenings and treatment for conditions discovered during screenings. To serve as a certified EPSDT provider, the federal law specifies that a provider need not be able to provide the entire package of screening, diagnosis, and treatments services; they may, however, have to make referrals for services they do not provide.

To receive Medicaid reimbursement for services provided to students, SBHCs must make their way through a tangle of federal and state legal requirements and administrative practices. By working with state Medicaid officials, SBHCs can identify the problem areas in their states and the potential solutions. Some of the issues SBHCs have grappled with in seeking Medicaid reimbursement are as follows:

Establishing Clients' Eligibility for Medicaid: While many SBHC clients come from families whose income is too low to afford them access to other health services, the relatively restrictive criteria of the Medicaid program exclude many children and adolescents in need of assistance.[12] This will be increasingly less common as coverage for all children below the poverty line is phased-in. But even for those who are potentially eligible, the arduous process of applying for Medicaid and establishing eligibility constitutes a formidable barrier. To reduce this barrier, some SBHCs have arranged for Medicaid eligibility workers to complete applications on-site at the health center.

Determining the Medicaid Status of Clients: In order to bill Medicaid, the SBHC must know whether or not students who receive services are eligible for Medicaid. Many students may not know that they or their family is eligible for Medicaid. The problem is further complicated by frequent changes in a child's Medicaid eligibility because of fluctuations in the family's income. SBHCs can mount special outreach efforts to students and their parents asking them to provide information regarding their Medicaid-eligibility, perhaps on their consent forms. Obtaining the information from the Medicaid agency itself may be difficult because to protect the confidentiality of information relating to individual Medicaid recipients, states adhere to conditions for release of information; SBHCs need to contact their state Medicaid agency to determine its rules and practices in this regard. Even if the state will provide lists of individuals eligible for Medicaid, manual comparison with a list of enrolled students may be too burdensome. SBHCs with some automated capacities may be able to significantly reduce the burden if their state can provide the information in a compatible, computerized format.

Matching Provided Services to Covered Services: Each state has its own rules regarding covered services, including the duration and scope of services and the types of providers that may bill for them. SBHCs must consider these state provisions when developing SBHC services and assessing the potential for Medicaid reimbursement.

Obtaining Certification as a Medicaid Provider: To receive Medicaid reimbursements providers must be certified by the state; states establish their own certification criteria. As nontraditional providers, SBHCs may have difficulty meeting state certification requirements. For the many SBHCs that are sponsored by more traditional providers such as hospitals, health departments and community health centers, the sponsor may serve as the certified provider. A few states do specifically authorize SBHCs to provide Medicaid services.

Negotiating Cumbersome Billing Procedures: The complexity of many states' Medicaid billing systems is notorious. Completing the necessary paperwork can be time-consuming; the Medicaid agency may demand claim forms completed to perfection; and providers complain that state Medicaid agencies often erroneously return correctly completed claims. As a result, the amount of time SBHC staff must devote to the process of billing for Medicaid services can undercut the cost-effectiveness of seeking Medicaid reimbursements. The problem may be less severe for SBHCs sponsored by entities such as community health centers or hospitals, which have considerable experience billing Medicaid and which may handle the SBHC's Medicaid billing. Some SBHCs have found that computerized billing systems are a cost-effective method for obtaining Medicaid reimbursements; others have hired private billing firms and found this effective.

Third-Party Billing Requirements: In order to reduce Medicaid costs, Medicaid providers are required to bill private insurers, prepaid health plans and other public or private entities that may be liable for services provided to Medicaid-eligible recipients. Another federal rule prohibits, with some exceptions, federal reimbursement for services available to non-Medicaid eligible individuals free of charge. Under this rule, providers must either bill all individuals who receive the service, or at least bill all those whose services are covered by other third parties. For SBHCs, this adds another layer of complexity to Medicaid billing, although the impact of this requirement is less for SBHCs than for other types of providers because many of the preventive health services SBHCs provide are not usually covered by health insurance.

Low Reimbursement Rates: In many states, the rate at which Medicaid services are reimbursed is low relative to the actual costs of providing the service. This factor, on top of the costs incurred by providers to bill for the services, can further undermine for SBHCs the cost-effectiveness of seeking Medicaid reimbursement.

Protecting the Confidentiality of Certain Services: In many cases, students require assurance that their parents will not be notified if they request services such as family planning, diagnosis and treatment of sexually transmitted diseases and counseling. The consent policies of a number of SBHCs accommodate this concern. However, certain aspects of the Medicaid program compromise this confidentiality. For instance, some states provide parents with an itemized list of all Medicaid-reimbursed services provided to family members. Also, to document their Medicaid eligibility to SBHC staff, students may need to gain access to the single Medicaid card provided to the family, which is most likely in the possession of the parent, a process that could result in their parents discovering the students' interest in these services.[13]

For SBHCs, the potential for augmenting their budgets through Medicaid reimbursements for services provided to students depends on policies and procedures determined largely at the state level. Also critical are factors specific to each individual SBHC, such as the proportion of the student population served for whom Medicaid eligibility can be established and the specific mix of services that the SBHC's student population needs. Ultimately, numerous factors may constrain the proportion of expenses most SBHCs can reasonably expect to obtain through Medicaid reimbursements. But drawing a reliable conclusion about the cost-effectiveness for a SBHC of pursuing Medicaid dollars requires a fairly detailed exploration of state Medicaid policies and practices.

As daunting a task as this exploration is, it is also worth remembering the huge number of dollars that are at stake in the Medicaid program.Furthermore, health professionals and public officials are increasingly coming to realize that SBHCs are an effective — and cost-effective — way to provide health care to children and adolescents. With this understanding may come a greater willingness to adapt state Medicaid policies to the needs and realities of SBHCs.

See Appendix D for your state contact who can provide information on the Medicaid program in your state and its potential for supporting your SBHC.

Federal contact for more information about Medicaid:

William Hiscock
Program Initiatives Branch
Medicaid Bureau
Health Care Financing Administration
East High Rise, Room 236
P.O. Box 26678
Baltimore, MD 21207
(410) 966-3275

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[1] The law is found at 42 U.S.C. §§ 1396-1396u. Regulations are at 42 C.F.R. Parts 430-498.

[2] Federal reimbursement of state Medicaid costs is called federal financial participation (FFP). The lower a state's per capita income, the higher its FFP; on average, states receive 57 percent reimbursement from the federal government. The costs to the state of providing family planning services are reimbursed at a special higher rate of 90 percent. Most of the states' administrative costs are reimbursed at a 50 percent rate; some are reimbursed at higher rates.

[3] Another quarter of Medicaid recipients are below the age of six; these younger children also account for ten percent of Medicaid dollars spent. Figures are for FY 1991, and were obtained from the Medicaid Bureau.

[4] Because of the connection between AFDC and Medicaid, in most states the agency responsible for Medicaid is the social services or welfare agency, rather than the health agency, or is an agency that has responsibility for both social services and health.

[5] Some states are permitted to exclude some recipients of SSI under special, more restrictive criteria for Medicaid eligibility.

[6] Living in poverty does not mean a child is eligible for AFDC. Each state determines how much income a family can have and still qualify for AFDC. Most states have set AFDC income eligibility limits significantly below the poverty line. Consequently, a provision conferring Medicaid eligibility that is not linked to AFDC status is needed to make all poor children eligible for Medicaid.

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[7] "Medically needy" individuals must be pregnant women, members of a family with dependent children, elderly, blind or disabled.

[8] States can opt to provide a more limited package of services to individuals who are covered as part of a state's optional medically needy program.

[9] Federally qualified health centers are health centers which receive federal funds under the Community Health Centers Program, the Migrant Health Center Program or the Health Care for the Homeless Program; or which do not receive such funds but meet all the requirements for a grantee under these programs. The Community Health Center Program is described in a separate section in this manual; these health centers are quite comprehensive and must meet numerous programmatic requirements.

[10] There is an exception for FQHCs; they must be reimbursed for their reasonable costs for services, which may be more than the state-set rate applicable to the same services provided by other providers. In addition, states must reimburse FQHCs for some services which they need not cover if provided by other providers. Among the extra reimbursable services of FQHCs are services provided by physicians' assistants, clinical psychologists and clinical social workers.

[11] A very helpful resource for understanding the EPSDT program and the ways SBHCs can participate in it is *EPSDT: A Guide for Educational Programs* (Sept. 1992), prepared by the Medicaid Bureau of the Health Care Financing Administration of the Department of Health and Human Services. To obtain a copy, contact the Medicaid Bureau in Baltimore, MD at (410) 966-3870.

[12] In 1990, just over one-half of children aged six to 18 who were living in poverty were covered by Medicaid; this proportion will increase as mandatory coverage of all poor children phases in. Of children aged six to 18 whose family incomes are between 133 percent of poverty, one quarter were covered; for those with family incomes between 133 and 185 percent of poverty, about one-tenth were covered. *Overview of Entitlement Programs: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Ways and Means Committee, House of Representatives (May, 1992).

[13] At least one state, California, has a program under which minors can qualify for Medicaid on their own to receive certain specified services including family planning, pregnancy care, mental health services, substance abuse services and treatment for sexually transmitted diseases and sexual assault.

CHAPTER EIGHT:
SECTION 330: COMMUNITY HEALTH CENTERS

The Federal Community Health Centers Program, Section 330 of the Public Health Service Act, is yet another important source of federal funds for general health services for children and adolescents.[1] Many SBHCs tap into this funding source indirectly; one-quarter of them are sponsored by community health centers.

The Community Health Centers Program has its origins in the 1960s War on Poverty. The program makes direct grants to public and nonprofit private agencies which provide health care — particularly primary health care — in medically underserved communities. Today, there are almost 600 federally supported community health centers in urban and rural communities. Grants can be made for the costs of planning and developing a center as well as for operating one.

The Bureau of Primary Health Care in the Public Health Service of the U.S. Department of Health and Human Services is responsible for the program, and in FY 1993 expects to make grants to community health centers (and to similar centers for migrants) totaling over 600 million dollars. Although the funds go directly from the federal government to the community health center, there are numerous points when state officials are afforded input into the grantmaking process.[2]

To receive a grant, a community health center must serve a population that the Secretary of Health and Human Services has determined is "medically underserved." A medically underserved population is defined as the residents of an urban or rural area that has a shortage of personal health services based on a number of factors including: the number of physicians in a geographic area in relation to the size of the population; measures of the health status of the area (specifically including infant mortality rates); and economic and demographic factors that affect access to and need for health care. In determining whether a population is medically underserved, the Secretary must consult with state and local officials.

Community health center grant funds may be used to cover the costs of delivering primary health services which the program defines as:

- diagnostic, treatment, consultation, referral and other services of physicians, nurse practitioners, nurse clinicians and physicians' assistants;
- diagnostic laboratory and radiologic services;
- preventive services such as nutritional assessment, preventive health education, well child care, immunizations, children's eye and ear exams, family planning, prenatal care and postnatal care;

- emergency medical services;
- transportation services for residents of the center's service area who have special access difficulties;
- pharmaceutical services; and
- preventive dental services.

They may also be used to cover the cost of a range of other "supplemental health services," among them mental health services and health education,[3] and environmental health services which detect and alleviate unhealthy environmental conditions in the area. Grant funds can also be used for other operating costs, including the costs of building acquisition and modernization, staff training and reimbursement of governing board expenses.

The amount of the costs for health services provided that are covered by the federal grant depends on the income of the client served. Community health centers must have a schedule of fees for services which has a discount for low-income individuals and families. Those with incomes at or below the official poverty line must receive services free of charge (nominal fees may sometimes be charged) and grant funds can be used for the full cost of their care. Those with higher incomes that are below twice the poverty line receive services at a discounted price, and grant funds are used to pay the uncompensated costs of these health services.[4]

Many SBHCs are sponsored by community health centers, and this type of indirect support may be the only way for SBHCs to tap into community health center funding. It may not be possible for a SBHC to itself qualify as a community health center. Community health centers serve what is called a catchment or service area, and they must serve **all** residents of the catchment area. Although it might be possible to define the catchment area as the school served by the SBHC, the federal program is very much focused on meeting the health care needs of entire communities, making a more limited approach to defining a catchment area highly problematic.

In addition, to receive a grant, community health centers must meet a broad range of programmatic, financial, planning, management and governance requirements and expectations.[5] For many SBHCs, meeting some of these requirements may be impossible. Some of the requirements are as follows:

An extensive array of services must be available. A community health center must provide directly, or through "firmly established arrangements" with other providers, all primary health care services; case management; and referral to providers of supplemental health services.[6]

Collection of fees from liable third-party payers and clients must be attempted. The center must make "reasonable efforts" to collect fees from clients charged under the fee schedule (with the discount for low-income clients). It must seek reimbursement from Medicaid and other public medical assistance programs for services to clients eligible for these programs, as well as from private health insurance that covers clients.

Services must be available promptly and in a way that insures continuity of care. This includes arrangements for after-hours care.

The center must have a governing board of nine to 25 members, half of whom are people served by the center. It is not clear whether parents of students who use the SBHC could serve in their place. Of the remaining governing board members, not more than half can be from the health care industry. The governing board must have authority to determine policy and make major resource decisions.

A quality assurance program must be ongoing.

Information about patients must be kept confidential. The center must have a system for maintaining the confidentiality of patient records.

Overall, health projects funded under the Community Health Centers Program are expected to be full-service primary care facilities which meet a broad range of community needs and are governed in part by the people they serve. While the breadth of these requirements probably rules out a SBHC qualifying as a community health center, they make community health centers attractive partners for collaboration with SBHCs. Those who wish to establish a new SBHC should consider seeking sponsorship from a local federally-supported community health center. Even without full sponsorship, it might be possible to develop other arrangements in which health center staff provide services to students at the SBHC.

While the bulk of the Community Health Centers funds go to maintaining services at existing community health centers, in the last three years funds have been available to start new community health centers and expand existing ones, part of a Department of Health and Human Services plan to expand access to primary care for the medically underserved by the year 2000.[7] Existing community health centers that request additional funds to expand service delivery through a school-based component must explain the need to expand in their annual applications, relating it to their objectives for the year.

The Public Health Service works with state health departments and state-based primary care system planning entities (primary care cooperative agreements and primary care associations) to identify the areas with the highest need for new community health centers — which receive priority in funding — and to link federal funding of new or expanded community health centers with state comprehensive health care planning.

The application process to start or expand a community health center is complex. Applications are made to the Regional Offices of the Public Health Service, which, along with statewide primary care planning entities, provides technical assistance in developing the application. The process begins with a letter of intent (by March 15 for FY 1993) followed with an extensive application (by June 1 FY 1993) that includes a detailed assessment of community needs and available resources; descriptions of the clinical program, management and financial arrangements and governance structure; a project plan; a budget; and assurances that the center will comply with various federal laws that apply to grantees.[8]

To learn more about the potential for receiving funding and the application process, contact the regional office of the Public Health Service that serves your state.

Federal contact for more information about Community Health Centers:

Jane Martin
Division of Programs for Special Populations — Perinatal and Child Health Branch
Bureau of Primary Health Care
Health Resources and Services Administration
Public Health Service
Parklawn Building, Room 912
5600 Fishers Lane
Rockville, MD 20857
(301) 443-7587

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[1] The Community Health Center program is at 42 U.S.C. §254c. Regulations are at 42 C.F.R. Part 51c. There is a related program for Migrant Health Centers.

[2] The Department of Health and Human Services gives funds to state agencies and nonprofit entities for Primary Care Services Cooperative Agreements, which are responsible for statewide primary care planning and coordination of resources and which are consulted in funding decisions. The Community Health Centers Program is also covered by Executive Order 12372, "Intergovernmental Review of Federal Programs," which is described above in the section entitled "The Flow of Federal Funds."

[3] The full list of supplemental services includes, in addition, hospital, home health, extended care, rehabilitative, dental, vision, allied health, therapeutic radiology, public health, ambulatory surgical and outreach services.

[4] In addition, the total federal grant may not cover the center's costs in their entirety; the proportion of total costs it can cover depends on the center's ability to raise other funds, the need for health services in the area and the extent to which the center provides services in an innovative way that can serve as a model for health service delivery.

[5] These requirements are spelled out in the authorizing statute, program regulations and a Bureau of Primary Health Care publication called *Program Expectations for Community and Migrant Health Centers*.

[6] The administering agency may also require a community health center to provide supplemental and environmental health services needed in the catchment area and feasible for the center. Centers that serve a population with a significant proportion of people with limited ability to speak English must have bilingual staff and other ways of providing care that is linguistically and culturally appropriate.

[7] In FY 1993, the amount available for starting new or expanding existing services is over 17 million dollars, with an additional half a million available for planning grants. In FY 1992, there was 28 million; in FY 1991, six million. These funds cover migrant health centers as well as community health centers.

[8] Guidance materials that come with the application suggest a maximum of 66 pages for narrative parts of the application.

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CHAPTER NINE: DRUG-FREE SCHOOLS AND COMMUNITIES - STATE GRANTS

The state grants program under the Drug-Free Schools and Communities Act (DFSC) is another potential state-controlled source of federal funds for SBHCs' substance abuse programs.[1] These funds are used for drug abuse education, prevention and early intervention activities.

The Division of Drug-Free Schools and Communities in the Office of Elementary and Secondary Eduction of the Department of Education oversees the state grants program, which will award almost 500 million dollars to the states in fiscal year 1993.

To receive DFSC state grant funds, states file an application which covers a three-year period (with yearly amendments), describes how the funds will be used and is available to the public. The amount allocated to each state depends on the size of the state's school-age population and the amount of funding it receives under Chapter I of the Elementary and Secondary Education Act, the federal program to improve educational opportunities for educationally deprived children. Every other year, each state must submit a report which describes: the drug and alcohol problems in its schools and the range of school policies that address the problem; the people served with DFSC state funds and the services provided; how high-risk youth have been targeted for service; and the model drug and alcohol abuse prevention programs found to be effective in the state. The report must also evaluate the effectiveness of state and local anti-drug and alcohol abuse programs.

At the state level, authority over the funds is split between the governor and the state educational agency, the state agency with state-wide authority over public elementary and secondary education. Seventy percent of the DFSC grant funds are allocated to the state educational agency, the remainder are allocated to the governor.

Except for those SBHCs sponsored by the school they serve, SBHCs cannot access directly the state educational agency's share of the DFSC state grant funds. At least 90 percent of these funds must be passed on to local educational agencies, which are the local boards of education or other authorities responsible for the public schools in a city, county, town or other political subdivision of a state. These funds are divided among local education agencies based on the relative enrollments of students in the schools they oversee. It may be possible for a SBHC with a non-school sponsor to gain access to these funds indirectly, through a contract or other arrangement with its local educational agency. Local educational agencies can use the funds for a wide variety of anti-drug programs, among them prevention and intervention counseling programs which the law states may be provided through a contract with a nonprofit organization that employs staff such as nurses, social workers, and other professionals trained to provide such counseling.[2] Indeed, the law prefers that services and programs supported by DFSC state funds utilize professional staff with specialized anti-substance abuse training.

The state educational agency may use the funds it retains for a number of activities, including supporting demonstration projects in drug abuse education and prevention or providing special assistance to enhance drug abuse education and prevention resources in areas that serve a large number of poor children or are sparsely populated.[3] Here again, the state agency can only grant these funds to local education agencies.

SBHCs may be able to directly access at least some of the funds that go to the governor, which must be used as follows:

- At least 42.5 percent of the funds must be used to make grants to public agencies or nonprofit private organizations for innovative, community-based programs of coordinated services for high-risk youth. Community-based organizations and parents groups have priority for assistance.[4]
- At least ten percent of the funds must be used for drug abuse resistance education (DARE) programs for elementary school students, which enable them to resist peer pressure to use drugs or alcohol. These grants must be made to partnerships of local boards of education or other local education agencies and entities which have experience with DARE programs.[5]
- At least five percent must be used for grants to local education agencies and private nonprofit organizations for drug abuse education, prevention or counseling services for students in elementary and secondary schools. Eligible services must replicate or expand upon a program that has a record of success at the state or local level and is appropriate for the students to be served based upon an assessment of their needs. Applicants for these funds must be local educational agencies.
- The remaining funds (up to 42.5 percent) can be used for grants to parents groups, community-based organizations, public agencies and other private nonprofit organizations for a range of anti-drug activities, among them development and implementation of local, broadly-based programs for substance abuse prevention, early intervention, referral for treatment and education of children of all ages. A catchall provision authorizes the governor to use these funds for grants for "other drug and alcohol abuse education and prevention activities consistent with the purposes" of the Drug-Free Schools and Communities Act.[6]

DFSC state grant funds may not be used for drug treatment, but only for education, prevention, early intervention and referral for treatment. Funded programs must convey a "no-use" message regarding drugs and alcohol. Except for the funds set aside for high-risk youth, the federal law contains no limits on who may be served with DFSC state grant funds. While the law contains many requirements regarding application procedures for local education agencies, specific application procedures for nonprofit organizations are determined by the state.

The federal law requires that the state make its application available to the public; SBHCs can obtain a copy to see how their state has used its DFSC state grants funds in the past. In the past, much of this funding has been used to train teachers and purchase anti-drug curricula.

See Appendix D for the state contact who can provide information on whether your state would support your SBHC with the governors' portion of DFSC funds and on how to apply. Contact your local school board or other local educational agency to explore the possibility of obtaining support for your SBHCs' substance abuse education and prevention activities through their DFSC allotment.

Federal contact for more information about the Drug-Free Schools and Communities State Grants Program:

Division of Drug-Free Schools and Communities
Office of Elementary and Secondary Education
Department of Education
400 Maryland Ave., SW
Washington, DC 20202-6439
(202) 401-1599[7]

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[1] The law is at 20 U.S.C. §§ 3171-3197 and § 3221. Regulations generally applicable to state-administered formula grant programs of the U.S. Department of Education are found at 34 C.F.R. Part 76.

[2] Other uses of funds granted to local education agencies include, for instance: development or acquisition of curricula; school-based prevention and early intervention programs; family drug abuse prevention programs, including education about substance abuse for parents; outreach, education, prevention and referral services for drop-outs; training for school personnel, law enforcement officials, judges and community leaders; community or public education programs; model alternative schools for youth with substance abuse problems; and "other programs of drug and alcohol abuse education and prevention" which are consistent with the purposes of the Drug-Free Schools and Community Act.

[3] Other uses for DFSC funds retained by the state education agency include training and technical assistance in drug abuse education and prevention for educational personnel, parents, law enforcement personnel and judges; development, identification and dissemination of model anti-drug curricula; and state agency administrative costs.

[4] The law uses the term "high risk youth," defined as someone under the age of 21 who has abused alcohol or other drugs, or is at high risk of doing so, and who: is a high-school dropout; has repeatedly failed in school; has been or is pregnant; is economically disadvantaged; is the child of a substance abuser; is a victim of physical, sexual, or psychological abuse; has had mental health problems; has attempted suicide; has committed a violent or delinquent act; or is a juvenile in a detention facility. Up to ten percent of the participants in a program for high-risk youth need not themselves be high risk if their participation will not significantly affect the service provided to high-risk youth.

[5] Eligible DARE programs must include instruction to teach elementary school students to recognize and resist pressures to experiment with alcohol or drugs, and cover a number of different specified topics, such as assertive response styles, stress management, self-esteem building, interpersonal skills and consequences of drug abuse. Programs must also involve parents, include instruction by law enforcement officials, use student leaders to influence younger students, emphasize activity-oriented methods which encourage student responses to problem-solving situations and award certificates to student participants.

[6] Other explicitly mentioned uses of these funds are: training programs for school personnel, parents, public service personnel and community leaders; development and distribution of public informational materials; technical assistance to community-based organizations and local education agencies to assist them in developing anti-drug abuse programs; coordination of drug abuse education and prevention programs with other community resources; establishment of centers which assist schools, organizations and community members in their anti-drug abuse education and prevention efforts; and establishment of drug-free school zones.

[7] The staffperson contacted at the agency declined to provide the name of someone available to answer questions about the DFSC State Grants program on the grounds that it is not the agency's role to provide technical assistance to potential sub-grantees.

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CHAPTER TEN:

TITLE X: GRANTS FOR FAMILY PLANNING SERVICES

Despite the potential for controversy, many SBHCs provide services related to family planning. Over two-thirds provide contraceptive counseling and referrals; over half diagnose and treat sexually transmitted diseases; over a quarter write prescriptions for oral contraceptives, and over one tenth dispense family planning devices. A few SBHCs do report receiving support for their family planning services through Title X of the Public Health Service Act, the federal government's family planning program.[1]

Title X makes grants to public and private nonprofit organizations to provide voluntary family planning services, which are defined as the educational, medical and social services needed to assist individuals to determine freely the number and spacing of their children. The Office of Population Affairs in the Public Health Service of the Department of Health and Human Services oversees Title X, which will make grants totaling about 160 million dollars in FY 1993. Although individual family planning service providers are eligible to apply for Title X funds directly, the funds primarily go to statewide or regional entities, such as state Departments of Health or Family Planning Councils, which then regrant the funds to service providers in their state.

An organization that receives Title X funds may use them for a wide variety of the costs of providing contraceptive and infertility services; these services constitute its "Title X project." Covered costs include, for instance, the costs related to information, education, counseling, physical examinations, laboratory tests, contraceptive supplies, general reproductive health care and diagnosis and treatment of infections which threaten reproductive health. Social services related to family planning and ancillary services needed to facilitate an individual's attendance at a family planning clinic are also covered. Costs related to prenatal care and obstetric services are **not** covered. Title X funds may not be used to provide abortions or promote the availability of abortion services, with the exception of providing pregnant clients with counseling on all of their options (see below). Title X funds also may not be used to purchase or construct buildings. Title X grants cover at least 90 percent but not 100 percent of a Title X project's costs.

Title X projects must fulfill a number of requirements, some of which may be problematic for SBHCs.

A broad range of services must be provided. These must cover the range of medically effective family planning methods (specifically including so-called "natural family planning" methods), infertility services and, for adolescents, in-depth information, counseling and referral to other medical and social service programs.[2]

Low-income individuals must receive priority for service. Individuals with family incomes at or below the poverty line must receive services free of charge. Those with higher family incomes that do not exceed 250 percent of the poverty line are charged according to a fee schedule with discounts based on family income. Individuals with higher family incomes may be served but must be charged a fee based on the reasonable costs of the services provided.[3]

Title X projects must provide services without regard to age, sex, marital status, number of pregnancies, race, religion, disability or national origin and must serve minors without requiring the consent or notification of their parents. When a minor desires confidential services, the minor's own income, rather than family income, must be used to determine fees.

Title X projects must seek reimbursement from liable public and private third-party payers. Projects must bill Medicaid and other public medical assistance programs for services to clients eligible for these programs, as well as private health insurance that covers clients.

Informational and educational materials that a Title X project develops or provides must be reviewed by an Advisory Committee which is responsible for insuring the materials' accuracy and suitability for the population or community served. The Advisory Committee must have five to nine members who are broadly representative of the community. In reviewing the materials, the Advisory Committee must take into account the educational and cultural background and standards of the community or population for whom the materials are intended.

Information about patients must be kept confidential.

Family planning services must be provided on a voluntary basis only. An individual may not be required to accept family planning services as a condition for receiving any other services or participating in any other programs conducted by the Title X grant recipient. An individual may not be coerced into choosing any particular method of contraception.

Upon her request, a pregnant client must be provided with non-directive, objective information regarding all of her options, including abortion, and referred to abortion providers if that is her choice. This is a departure from the "Gag Rule" regulations issued under the Reagan administration that forbade Title X projects from providing either abortion referrals or counseling that did not discourage women from choosing abortion. On February 5, 1993, President Clinton suspended the Gag Rule, reinstated pre-Gag Rule guidelines which require Title X projects to make non-directive options counseling available to clients with unwanted pregnancies, and issued proposed Title X regulations that omit the Gag Rule.[4]

There are a number of other requirements Title X grantees must ordinarily meet that may be waived by the Secretary of the Department of Health and Human Services if the grantee shows there is good cause for not meeting the requirement. Ordinarily, Title X projects must provide:

- the medical services related to family planning and effective use of contraceptive devices (physical examinations, prescriptions and supplies), under the direction of a physician with special family planning experience;
- social services, such as counseling and referral, that are related to family planning;
- outreach to the community regarding the purposes of Title X and the availability of services;
- participation by representatives of the community served in the development and implementation of the Title X project;
- coordination with other health care services; and
- orientation and in-service training for staff.

Although many SBHCs provide family planning services, very few support them with Title X funds. The requirement that minors be served without requiring the involvement of their parents conflicts with the policies of most SBHCs requiring some form of parental consent to receive SBHC services. It is worth noting here that in most states, state law authorizes the provision of family planning services to minors without parental involvement, so SBHCs can comply with this Title X requirement and still be in compliance with state law.

In addition, Title X projects typically provide significantly more comprehensive family planning services than many SBHCs provide, and adhere to specific program expectations regarding standards of practice and quality of care. To obtain indirect support from Title X for family planning services, SBHCs should explore the potential for partnerships with Title X projects in which Title X staff provide family planning services and outreach on-site at the SBHC.

To apply for Title X funds, statewide family planning entities and individual service providers must submit an application which describes the proposed Title X project, including how it will meet Title X requirements found in the law and regulations, the standards facilities used by the project will have to meet, the qualifications of project staff and measurable, objective goals for the project. A budget which estimates project costs and income and justifies the amount of funds requested must also be included.[5]

The Department of Health and Human Services determines which applicants to fund based on: the number of people, especially low-income people, the project will serve; the local need for family planning services; the need of the applicant for federal funding; the availability of non-federal resources in the applicants' community and their commitment to the project; the adequacy of the applicant's facilities and staff; the ability of the applicant to make quick, effective use of federal funds; and the extent to which the plan for the project adequately provides for meeting the requirements imposed on Title X projects.

Finally, it is worth noting that Title X is not the only source of federal support for family planning services. States may authorize the use of funds under the Maternal and Child Health Block Grant, the Preventive Health and Health Services Block Grant and the Social Services Block Grant (described below) for family planning purposes. In addition, community health centers provide family planning services and Medicaid covers many family planning medical expenses for eligible individuals.

See Appendix D the statewide family planning contact that can provide information on the possibility of receiving Title X funds as a sub-grantee.

Federal contact for more information about Title X Project Grants for Family Planning Services:

Lucy Eddinger, Public Affairs Officer
Office of Population Affairs
Public Health Service
Department of Health and Human Services
North Building, Suite 1115
4340 East-West Highway
Bethesda, MD 20857
(301) 594-4000

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[1] The law is found at 42 U.S.C. §§300 - 300a-7. Regulations are at 42 C.F.R. Part 59.

[2] The regulations specifically permit organizations which do not provide the full array of contraceptive methods to participate as part of a larger Title X project which provides the full range of family planning services.

[3] Services may also be provided free of charge if the Title X Project Director determines that an individual whose family income exceeds the poverty line is for another good reason unable to pay.

[4] 58 Fed. Reg. 7462 and 7464 (February 5, 1993).

[5] Title X is a program covered by Executive Order 12372, which is described above in the section entitled "The Flow of Federal Funds;" applicants must contact their state's designated single official.

CHAPTER ELEVEN:
SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

Many SBHCs provide services to pregnant and parenting students. About a quarter provide prenatal care and most make referrals for prenatal care; one-fifth provide pediatric care to infants of adolescents. To enhance these services, SBHCs may want to participate in the Special Supplemental Food Program for Women, Infants, and Children, known as the WIC program.[1] Under the WIC program, certain low-income women and young children at "nutritional risk" receive free nutritious foods.[2] In almost all states, participants receive vouchers or coupons redeemable for specific foods at participating retail food stores; in three they receive food directly by picking up their food packages at specific distribution sites or by home delivery. In addition, all women participating in the program and the parents or other caretakers of children participating in the program receive education about nutrition, including, for pregnant women and new mothers, support for breastfeeding. Participants also receive information about substance abuse, referrals for substance abuse counseling and treatment, if necessary, and information about Aid to Families with Dependent Children, Food Stamps, child support enforcement services and Medicaid. Local health and welfare agencies and organizations, referred to as "local agencies" by the WIC program, serve as the providers of WIC benefits. WIC food and nutrition services are intended to be an adjunct to good health care.

The Supplemental Food Programs Division of the Food and Nutrition Service in the Department of Agriculture oversees the WIC program. In FY 1993, the program will grant over 2.8 billion dollars to the states, with 2.1 billion dollars going to food costs, and the remainder for program services and administrative costs. In FY 1992, an average of over five million women and children received WIC benefits each month.[3] Each state's allocation is based on a complex formula which takes into account the previous year's food costs and participation rates of those most in need of services.

At the state level, the state health agency is usually responsible for the WIC program. To receive its WIC funds, the state agency submits an annual state plan describing how the program will be operated in the state and how WIC funds will be spent. Members of the public must have the chance to comment on the plan while it is under development.

To be eligible for WIC, a woman must be pregnant, postpartum (up to six months from the end of her pregnancy) or breastfeeding her infant (for up to one year postpartum); children must be under the age of five. In addition, eligible women and children must be "at nutritional risk" and be low-income.

Nutritional risk is defined broadly in the WIC program. Women or children qualify as being at nutritional risk if they have a harmful nutritional condition shown by measurements of biochemistry or body size (for instance, anemia, abnormal weight gain during pregnancy or low birthweight); another nutritionally-related medical condition (for instance, pre-eclampsia or failure to thrive); a dietary deficiency that threatens health; or a condition that predisposes an individual to inadequate nutritional patterns or nutritionally-related medical conditions (for instance, substance abuse or factors associated with high-risk pregnancy, such as adolescent pregnancy). An applicant's nutritional risk is determined by a medical and nutritional assessment, which must be conducted by a "competent professional authority" who is a physician, registered nurse, certified physician's assistant, nutritionist, dietician, or a state or local medically trained health official.

States have some flexibility in determining income eligibility guidelines. They can either set eligibility at the standard for reduced-price lunches under the National School Lunch Act, which is a family income of up to 185 percent of the poverty line, or they can set eligibility at the income level they use for free or reduced-price health care, so long as it is not less then 100 hundred percent of the poverty line, and not more than 185 percent of the poverty line. Recipients of Aid to Families with Dependent Children, Food Stamps and Medicaid benefits automatically satisfy the income eligibility criteria.

WIC is not an entitlement program, so everyone who is eligible does not necessarily receive benefits; the number of eligible people who are actually served depends on the amount of funding available. Each local agency is given a certain number of participant "slots." Once all the slots are filled, eligible women and children are put on a waiting list, which is prioritized according to the type or seriousness of the applicant's nutritional risk. The waiting list is used to fill slots as they open up.

Local agencies play a critical role in providing WIC benefits. They have a number of specific responsibilities, among them:

Determining applicants' eligibility: To determine whether an applicant is at nutritional risk, local agencies perform medical and nutritional assessments which include, at a minimum, measurements of height and weight and, with some exceptions, anemia tests.[4] They also determine whether an applicant meets the income guidelines, using an application form supplied or approved by the state agency. Local agencies must determine whether an applicant meets the eligibility criteria within 20 days of when the applicant first asks to apply.[5] When a local agency finds applicants ineligible, it must explain the reasons in writing and notify applicants of their right to appeal the decision to the state agency.

Prescribing food packages for participants: Based on six different food packages, local agencies determine what WIC foods each participant should receive in light of the individual's medical needs, nutritional condition and cultural eating practices.

Providing nutrition education, promoting breastfeeding and providing information about substance abuse: The local agency must provide directly, or through arrangements with another agency, nutrition education, and must encourage pregnant participants to breastfeed unless breastfeeding is contraindicated for health reasons. Nutrition education, which may be provided individually or in group sessions, must be made available to adult participants and the parents or caretakers of infant and child participants.[6] Local agencies develop annual nutrition education plans which they submit to the state agency. The local agency must integrate in its nutrition education program information about the dangers of substance abuse, maintain a list of local substance abuse counseling and treatment programs and make referrals.

Distributing food or food coupons: Participants pick up WIC food coupons at the local agency. (In some circumstances, food coupons may be mailed.) Local agencies may also be the site where food is directly distributed.

Maintaining waiting lists: Local agencies maintain prioritized waiting lists for WIC services and are responsible for notifying applicants that they have been put on a waiting list and for filling slots as they become available. Local agencies must provide individuals placed on the waiting list with referrals to other sources of food assistance.

Maintaining records and filing reports: Local agencies must maintain records regarding applicants, participants, and other program operations and submit regular reports to the state agency.

Local agencies that would like to operate a local WIC program submit a written application to the state agency, which must approve or disapprove the application within 30 days. The state must provide reasons justifying a decision to disapprove the application, and the applicant may appeal the decision.[7] To serve as a local agency, an entity must be a local public or private nonprofit health or welfare agency; provide health services free or at reduced cost to residents of low-income areas (or be able to arrange for provision of such health services); serve a population with low-income women, children, and infants; and have the staff, equipment, and capability to fulfill the responsibilities of local agencies.

The state agency accepts local agency applications according to a priority system based on the need for WIC services of the residents in the area the local agency would serve. Also, first consideration goes to applicants that are health agencies directly providing ongoing, routine, pediatric and obstetric care. More than one local agency may serve a population or area if needed to fully serve the area or population.

Based on claims submitted at least once a month by the local agency, the state agency provides WIC funds to the local agency. While no WIC funds may be used to provide health services, the local agency can use them to cover the costs of conducting nutritional assessments and determining eligibility, providing nutrition education, and administering the WIC program. Coverable WIC costs include, for instance, staff salaries for time spent on WIC activities, educational materials, staff training and equipment, supplies and laboratory fees used in determining applicants' nutritional risk.

In some states, WIC funds are very tight, and few, if any, new local agencies can be approved. But in the next few years, the WIC program could expand dramatically. President Clinton has called for increasing the levels of WIC funding so that by 1996 all applicants who meet eligibility requirements can be served. And Congress has signaled its approval; the WIC appropriation for FY 1994 is much larger than for FY 1993.

SBHCs that serve many pregnant and parenting students may want to explore adding a WIC component to their program. In addition to providing participants with nutritious foods and nutrition education, the availability of WIC benefits could serve as an incentive to bring pregnant students into the SBHC where they may also receive prenatal care.

See Appendix D for the state contact who can provide you with information on your state's WIC program and on whether your SBHC can operate a local WIC program.

Federal contact for more information about the WIC program:

Ms. Alberta Frost, Director
Supplemental Foods Program Division
Food and Nutrition Service
Department of Agriculture
3103 Park Center Drive
Alexandria, VA 22302
(703) 305-2746

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[1] The law is at 42 U.S.C. §§ 1786-1788. Regulations are at 7 C.F.R. Part 246.

[2] Typical WIC foods include infant formula, cereal, milk, cheese, eggs, juice, peanut butter and legumes. Nutritionally equivalent foods can be substituted to accommodate a recipient's cultural eating patterns.

[3] *The WIC Newsletter*, Center for Budget and Policy Priorities, January 22, 1993.

[4] As noted above, nutritional risk assessments may be conducted only by certain kinds of health professionals. If none are on the staff of a local agency, the local agency can determine whether an applicant is at nutritional risk based on referral data supplied by such a person who is not on the staff of the local agency.

[5] The time frame may be shorter for certain situations where there is a need to expedite the decision because the applicant needs benefits more quickly.

[6] A person's failure to participate in nutrition education does not disqualify her from the WIC program.

[7] If a local agency's application is denied because of a lack of funds, it must be notified when funds become available.

CHAPTER TWELVE:
SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant, Title XX of the Social Security Act, funds an array of social services.[1] At the federal level, the Office of Community Services in the Administration for Children and Families of the Department of Health and Human Services oversees the Social Services Block Grant, which in FY 1993 will grant over two billion dollars to the states. Each state's share is based on its portion of the total population of the United States.

States have broad discretion in determining both which social services to support with Social Service Block Grant funds and who is eligible to receive funded services. All the law requires is that the funds be used for social services that are directed at any of the following goals: achieving or maintaining economic self-support or self-sufficiency in order to reduce or prevent dependency; preventing or remedying neglect or abuse of children or adults who are unable to protect themselves; preserving or rehabilitating families; preventing inappropriate institutional care by providing community or home-based care; or securing admission to necessary institutional care. States may use the funds for related staff training, administration, planning or evaluation, as well as for directly supporting social services.

Virtually all states use Social Services Block Grant funds for child day care, which is of interest to those SBHCs that provide day care for children of students or would like to do so.[2] Child care providers must meet state and local child care standards to receive these block grant funds. Also of potential interest to SBHCs is Social Services Block Grant funding of counseling services in almost half of the states; and unmarried parents services and substance abuse services in just over one-tenth of the states.[3]

The law specifically prohibits the use of Social Services Block Grant funds for medical services, with some exceptions; the most important for SBHCs is family planning. About half of the states devote some of their Social Service Block Grant funds to family planning services. Funds can also be used for rehabilitation or for initial detoxification of a drug-dependent person. Other medical services may only be provided with these funds if they are an essential but minor part of another social service which can be supported with these funds. The law also specifically prohibits use of Social Service Block Grant funds to provide educational services which the State makes generally available to residents at no charge.[4]

To receive its Social Service Block Grant funds, a state must file a preexpenditure report which describes the services it intends to support with the funds and the individuals who will be served. The public must have the opportunity to comment on the preexpenditure report during its development and after it is completed. States must also submit reports at the end of the fiscal year describing how the funds actually were used; copies of the annual report must be available to the public.

Because states have so much discretion in deciding how to spend their Social Service Block Grant funds, SBHCs should consider exploring the possibility of funding their non-medical or family planning services through the block grant; indeed, a few SBHCs currently report receiving a small portion of their operating budget from the block grant. However, SBHCs should be aware that Social Service Block Grant funds are very tight, their value having declined in real terms by over 40 percent since 1981 when Congress created the Social Services Block Grant out of pre-existing social services grant programs.

See Appendix D for the state contact who can provide you with information on the possibility of obtaining funds from the Social Services Block Grant for your SBHC.

Federal contact for information about the Social Services Block Grant:

Bryant Tudor
Office of Community Services
Division of State Assistance
370 L'Enfant Promenade, SW
Washington, DC 20447
(202) 690-6275

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[1] The law is at 42 U.S.C. §§ 1397–1397e. Regulations which apply to a number of block grant programs are found at 45 C.F.R. Part 96; regulations specific to the Social Services Block Grant are at 45 C.F.R. §§ 96.70–96.73.

[2] The other services supported by block grant funds in virtually all states are protective services for children and home based services such as homemaker or companion services.

[3] Information on the states' use of this block grant is for fiscal year 1991 and is from *Overview of Entitlement Funds: Background Materials and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, House Ways and Means Committee (May, 1992). Among other frequently funded services are case management; adoption assistance; foster care; information and referral; special services for the disabled, children, or juvenile delinquents; social support; and prevention/intervention.

[4] The limitations on use of Social Service Block Grant funds for medical and educational services, as well as some other limitations not relevant to school clinics, can be waived by the Secretary of the Department of Health and Human Services if the state shows that there are extraordinary circumstances justifying the waiver.

CHAPTER THIRTEEN:
CHILD CARE AND DEVELOPMENT BLOCK GRANT

The Child Care and Development Block Grant (CCD) is another potential source of support for SBHCs that operate day care

programs for the children of their students.[1] The Division of Child Care in the Administration for Children and Families of the Department of Health and Human Services oversees the program, which will distribute over 800 million dollars to the states in FY 1993. Each state's share is based on the number of children below five years old in the state, the number of children in the state who receive free or reduced-price meals through the School Lunch Program and the state's per capita income.

The purpose of the CCD block grant is to improve the availability, affordability, and quality of child care services. Accordingly, CCD block grant funds are used for a range of services and activities. States must expend just over two-thirds of their grant to provide child care services through a system of contracts or grants with child care providers and a system of certificates or vouchers which parents use to obtain care from the provider of their choice. Parents must be given the option of choosing either a child care slot with a provider who has a grant or contract with the state or a child care certificate. Child care services under the CCD Block Grant are provided on the basis of a sliding fee scale; assisted parents may have to assume some part of the cost of the child care service, depending on their income. Other portions of the block grant are reserved for activities aimed at improving the quality of child care and the development of before or after-school-care and early childhood development programs.

To be eligible for subsidized child care services under the CCD Block Grant, a child must be under the age of 13 and have a family income that is no more than three-quarters of the state median income for a family of the same size.[2] The child must also live with a parent or parents who are working or are in an educational or job-training program. Children from very low-income families and children with special needs must receive priority for child care certificates and subsidized slots.

The federal law imposes very few requirements on the providers of child care services subsidized by the CCD Block Grant; instead the law emphasizes maximizing parental choice in the selection of child care provider. It does require that providers allow parents unlimited access to their children while they are in the providers' care. It also requires that providers comply with all applicable licensing and regulatory requirements of state and local law. If state law does not require that a provider be licensed, the provider must register with the state. In addition, all states are required to impose some basic standards on providers related to safety of the building and premises, control of infectious diseases and health and safety training of staff.

To receive CCD Block Grant funds, the state submits an application which includes a multi-year detailed plan that outlines how the funds will be spent. The state agency responsible for the funds and for development of the plan must hold at least one public hearing on the plan, and must consult with local authorities to determine local child care needs and resources. Annual reports at the end of the fiscal year are also required.

See Appendix D for the state contact who can provide information on the possibility of obtaining funds from the Child Care and Development Block Grant for your SBHC.

Federal contact for information about the Child Care and Development Block Grant:

Division of Child Care
Children's Bureau
Administration for Children and Families
Department of Health and Human Services
Aerospace Building, 5th Floor
370 L'Enfant Plaza, S.W.
Washington, DC 20447
(202) 401-9326

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[1] The law is at 42 U.S.C. §§ 9858 9858q. Regulations are found at 45 CFR Part 98.

[2] States may choose to include children up to the age of 19 who are physically or mentally incapable of self care.

CHAPTER FOURTEEN:

DIRECT GRANTS FOR INNOVATIVE, DEMONSTRATION OR SPECIAL PROJECTS

Every year, the federal government grants millions of dollars to health services and health-related projects which are in some way innovative, which can serve as models for the country or which are in some other way special. The *Federal Register*, published on every day of the work week, prints notices that announce the availability of these funds, identify funding priorities and project requirements, and describe application procedures. Many of these programs require that funded programs include an evaluation component.

The following are some of the grant programs which may be of most interest to SBHCs.

The legislation authorizing the **Maternal and Child Health Services** Block Grant sets aside some of the appropriated funds which the Department of Health and Human Services uses to make grants for specified maternal and child health activities, including special projects of regional and national significance, called SPRANS grants.[1] The Maternal and Child Health Bureau in the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services administers these grants. Of the just under 100 million dollars available for these grants in FY 1993, about one quarter will fund new projects or competitive renewals; the remainder will go to continuing projects with multi-year grants.

In administering the SPRANS grant program and selecting projects, HRSA currently emphasizes projects that improve the delivery of services to culturally identifiable populations of women and children who have encountered barriers to obtaining health care. Funded projects also should be part of community-wide comprehensive initiatives, reflect coordination of public health and primary care activities, and fill gaps in the health system for at-risk mothers and children. In addition, they should be aimed at achieving objectives for maternal, infant, child and adolescent health and health services identified in *Healthy People 2000*.

HRSA divides SPRANS grants into a number of categories, each with its own particular priorities for funding. The most relevant to SBHCs are the grants for Maternal and Child Health Improvement Projects. Among the goals of these demonstration projects are reducing infant mortality and morbidity, and enhancing the health of children and adolescents by preventing violence and unintentional injuries and by developing resources for improving their access to health care. In FY 1993, some two million dollars will go to new and competing renewals for these primary and preventive health services projects for women and children. Also relevant to SBHCs are the grants for Healthy Tomorrows

Partnerships for Children, which also aim at improving children's and adolescents' access to health services, including preventive services. In FY 1993, 250 thousand dollars will be available to support five new Healthy Tomorrows projects.

In the last two years, HRSA has issued announcements for applications for SPRANS grants in April, with the deadlines for the different categories of grants, largely in May and June. In addition to concerns and priorities mentioned above, HRSA uses the following criteria to select projects for funding: quality of the project plan; need for the project; project cost-effectiveness; the project's contribution to the advancement of maternal and child health services; the project's ability to make rapid, effective use of the funds; the effectiveness of the project in collecting the cost of services from public and private third-parties; the project's integration with related health programs, among them Title V; the soundness of project management; and the project's plans for evaluation. For more information about Maternal and Child Health SPRANS grants, contact:

Dr. Audrey Nora
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 18-05
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2170

The **Drug-Free Schools and Communities Act** (DFSC) also sets aside some funds for a number of direct grant programs. Of most relevance to SBHCs are the Federal Activities Grants.[2] The Division of Drug-Free Schools and Communities in the Department of Education administers these grants, which will total about five million dollars in FY 1993.

DFSC Federal Activities Grants are used to support the development, implementation, evaluation and dissemination of educational strategies and programs that are aimed at preventing substance abuse. Program regulations permit funding of a wide variety of substance abuse prevention activities and types of projects: for instance, comprehensive substance abuse education and prevention programs for students in elementary or secondary schools; after-school or other community-based programs for students at high risk of abusing drugs; and innovative programs targeted at students who have been suspended from school for substance abuse, who are children of substance abusers or who are members of other special populations. Eligible grant recipients include state and local education agencies, institutions of higher education and other nonprofit organizations. To receive a DFSC Federal Activities grant, applicants must provide a quantitative assessment of the substance abuse problem in their school, and have procedures for monitoring the problem during the time of the project.

In administering the program, the Department of Education may select priorities which significantly narrow the types of programs that are funded. For FY 1993, citing data showing high rates of tobacco and alcohol use by young adolescents, the Department limited new DFSC Federal Activities Grants to projects that focus exclusively on preventing use of these two drugs.

The Department of Education issued a notice that DFSC Federal Activities funds for FY 1993 were available in September of 1992; final applications were due on December 9, 1992. Criteria for selecting among applications for DFSC grants programs include the quality of the project's concept design and its potential for improving substance abuse education and prevention activities; the plan of operation; the qualifications of key personnel; the quality of the evaluation plan; the commitment and capacity of the applicant; and the relationship of the project to policies adopted under Drug-Free Schools and Campuses regulations. For more information about DFSC Federal Activities Grants contact:

Carol Chelemer
Division of Drug-Free Schools and Communities
Office of Elementary and Secondary Education
Department of Education
400 Maryland Avenue, S.W.
Room 2123
Washington, DC 20202
(202) 401-1258.

The Department of Health and Human Services also oversees a potential source of funding for innovative substance abuse prevention projects. **Demonstration Grants for the Prevention of Alcohol and Other Drug Abuse Among High-Risk Youth** made approximately 50 million dollars in grants in FY 1992.[3] The program is currently undergoing some changes as a result of the reorganization of the former Alcohol, Drug Abuse, and Mental Health Services Administration in 1992. The newly created Center for Substance Abuse Prevention (CSAP) in the Substance Abuse and Mental Health Services Administration will now oversee the program.

The program makes grants to public agencies and private nonprofit organizations to support projects that demonstrate effective, community-based models for preventing or treating substance abuse by high-risk youth.[4] In recent years the program has focused on projects which are client-centered and seek to reduce substance abuse by decreasing the factors in the high-risk youth, and his or her family, school, peers and neighborhood which increase the likelihood that he or she will become a substance abuser.

In November of 1992, CSAP withdrew the notice of availability of funds that had previously been issued under this program in March of 1991 by the now-defunct Office for Substance Abuse Prevention. The November announcement stated that several revisions in the program were being made. As of June, 1993 a subsequent, updated notice had not been issued. For more information about Demonstration Grants for the Prevention of Alcohol and Other Drug Abuse Among High-Risk Youth contact:

Ms. Rose Kitrell
High Risk Youth Branch
Division of Demonstrations for High Risk Populations
Center for Substance Abuse Prevention
Substance and Mental Health Services Administration
Department of Health and Human Services
Rockwall II Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3958

Adolescent Family Life Demonstration Grants (AFL), Title XX of the Public Health Service Act, is the only federal program that focuses exclusively on teen pregnancy issues.[5] Originally authorized in 1981, both the statute itself and program policies reflect the very conservative approach to sexuality issues of the Reagan and Bush administrations. This has left the program with certain features which limit its potential for SBHCs. The Office of Population Affairs in the Department of Health and Human Services oversees the program, which in FY 1993 made grants totaling about seven and half million dollars, all to projects which had previously received funding.

Much of the focus of the AFL grants program is to promote sexual abstinence for adolescents and adoption for pregnant adolescents. AFL grants are made to programs which carry out one or both of two types of projects. "Care projects" provide health and other services to pregnant and parenting adolescents and their families. Care projects must provide, either directly or through referral networks, ten core services, including: pregnancy testing and maternity counseling; adoption counseling and referral; primary and preventive health services (including prenatal and postpartum care); nutrition counseling; referral for sexually transmitted disease treatment; referral to pediatric care; family life education services (which cover the problems of adolescent pre-marital sexual relations, provide information on adoption and on the responsibilities of parenting and sexuality, and promote parents as providers of sex education); educational and vocational services; mental health services; and family planning counseling and referral. AFL grant funds cannot be used to provide contraception, except in certain limited circumstances. Care projects may provide a number of other social services such as family counseling and child care.

The second type of AFL projects are "prevention projects." These are projects aimed at preventing adolescent sexual activity. While they may provide a number of core services, and some of the additional social services, these may not provide family planning counseling or referral. Guidance that comes with the AFL application kit stresses prevention projects that are "value-based, family-centered approaches to promoting adolescent premarital abstinence." AFL funds have been used to fund the development of very conservative, value-laden and biased programs like Sex Respect and Teen-Aid.

The limited approach permitted to projects funded with AFL grants, and in particular the limitations on family planning information and services, make the AFL grants program highly problematic for many SBHCs. Another problematic requirement is that with few exceptions, parents must be notified when an adolescent requests services from the AFL project, and must give their permission for non-pregnant adolescents to participate.

In FY 1993, AFL funds were only sufficient to continue funding of previously-funded projects. When there are funds available, criteria used to select proposals include the incidence of adolescent pregnancy and low-income families in the area the project will serve; the availability of programs serving pregnant and parenting adolescents in the area the project will serve; the capacity of the applicant; the extent to which the project uses existing programs, facilities and other sources of funding; the extent of community commitment to and involvement in the project; and the innovativeness of the project. For more information about Adolescent Family Life Demonstration Grants, contact:

Florence Meltzer
Office of Adolescent Pregnancy Prevention Programs
Office of Population Affairs
Public Health Service
Department of Health and Human Services
North Building
Suite 1115
4340 East-West Highway
Bethesda, MD 20857
(301) 594-4004.

There is relatively little federal funding for general school health education projects. One small grants program, the **Comprehensive School Health Education Program** (CSHE), is part of a larger program, the Secretary's Fund for Innovation in Education.[6] The Office of Education Research and Improvement administers CSHE grants, and in FY 1993 will make CSHE grants of about four and half million dollars, with about one million going to approximately a dozen new projects.

The Fund for Innovation in Education supports programs or projects which develop and disseminate innovative educational approaches. Grants from the fund can be made to state education agencies, local education agencies, institutions of higher education and private or other public organizations. CSHE encourages the provision of comprehensive school health education in elementary and secondary schools, which covers education in the areas of personal health and fitness; nutrition; mental health; prevention of chronic diseases; substance abuse; accident prevention and safety; community and environmental health; effective use of health care; and development and aging.

Over the years, CSHE has supported a broad variety of activities, for instance development and assessment of comprehensive school health programs, training of teachers and other school personnel, identification of model programs, and dissemination of information to schools. Funded projects generally meet statewide or at least school district-wide needs; SBHCs might participate as a collaborator in a more broadly-based project. For fiscal year 1993, the Department of Education announced that it was particularly interested in projects which train teachers and school personnel to participate in programs in which schools work with families and the community to provide health education to students in kindergarten through the eighth grade.

The Department of Education issued a notice that CSHE grants for FY 1993 were available in September; final applications were due in December of 1992. Criteria for evaluating applications include the need for the project; the quality of the plan of operation; the quality of key personnel; the reasonableness of the budget; project cost-effectiveness; the quality of the evaluation plan; and the adequacy of project resources. For more information about the Comprehensive School Health Education Program, contact:

Ms. Shirley Jackson
Department of Education
555 New Jersey Avenue, N.W.
Room 300-Q
Washington, DC 20208
(202) 219-1556.

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[1] Other maternal and child health activities funded with this money are related research and training, hemophilia programs and genetic disease projects. The authority for SPRANS grants is at 42 U.S.C. §§ 701 and 702. Regulations are at 42 C.F.R. Part 51a. Notices for FY 1992 and FY 1993 funds are at 57 Fed. Reg. 13367-13373 (April 16, 1992) and 58 Fed. Reg. 17418-17419 and 19828-19835 (April 2 and April 16, 1993).

[2] The law is at 20 U.S.C. §§ 3182 and 3212. Regulations are found at 34 C.F.R. Parts 231 and 235. The notice of availability of FY 1993 funds is at 57 Fed. Reg. 43514-43515 (September 21, 1992). Other DFSC grant programs are the Emergency Grants made to local education agencies with particularly severe substance abuse problems; School Personnel Training Grants made to state and local education agencies; and the Demonstration Grants made to institutions of higher education.

[3] The law is at 42 U.S.C. §290bb-23.

[4] The definition of "high-risk youth" for purposes of this program is quite similar to the definition used in the State Grants program of the Drug-Free Schools and Communities Program (see footnote 45.)

[5] The law is at 42 U.S.C. §§ 300z-300z-7. Final regulations have never been issued for the program. Materials which come with the applications packet, including documents entitled *Additional Information for AFL Grantees Applying for Competing Renewal Applications* and *Assurances Required by Title XX, Public Health Service Act,* spell out program policies and expectations. This Title XX should not be confused with Title XX of the Social Security Act, which is the Social Services Block Grant.

[6] The law is at 20 U.S.C. §§ 3151 and 3155. The notice of availability of FY 1993 funds is at 57 Fed. Reg. 43507-43509 (September 21, 1992).

CHAPTER FIFTEEN:

PUTTING IT TOGETHER: THREE STATE CASE STUDIES

Thus far this manual has described and assessed individual federal funding sources in the light of the needs and realities of SBHCs. This section shifts focus, and examines how SBHCs in particular states have developed in the context of state-level policy and resources, with attention to the extent to which federal sources of funding have been utilized. The New Jersey and New Mexico case studies illustrate state-level efforts to promote a system of SBHCs within the state, while the California case study describes the experience of SBHCs trying to achieve financial stability in a state with a complex set of multiple funding streams.

New Jersey

In New Jersey, school-based and school-linked health services are provided primarily as part of a package of school-based or linked social, educational, employment and health services which receive substantial support from the state under the New Jersey School Based Youth Services Program (SBYSP).[1] Today, 30 SBYSP centers operate at or near schools in New Jersey's 21 counties.

The New Jersey Department of Human Services developed the SBYSP in response to the numerous problems afflicting New Jersey's teenagers, such as high rates of teenage substance abuse, suicide, pregnancy and parenting, mental illness, academic failure and dropping out of school, unemployment and untreated health problems. The SBYSP was first implemented in 1988.

The SBYSP addresses the multiple problems of adolescents by offering linked health, social, and employment services and recreational activities in an accessible, unstigmatized setting. A "one-stop shopping" approach that provides services at or near where many teens already are — the school — makes SBYSP projects accessible. Because SBYSP projects offer a range of services and recreational opportunities that are open to all students, students do not view SBYSP as a stigmatized program for troubled students. SBYSP materials stress the importance of including interesting and attractive activities in the program, and of providing students with what they most want: "caring adults who [are] non-judgmental and help them with decision making."[2]

The SBYSP was initially targeted to reach adolescents between the ages of 13 and 19, and so most SBYSP projects are connected with high schools. Several also serve middle schools and a few are connected with vocational schools. Recently, SBYSP projects began to serve elementary schools as well. Projects operate in urban, suburban and rural school districts. Just over half are located in the school they serve; the remainder are located nearby.

The mix of services provided at each project site varies. Each project must provide core health, mental health and employment services including crisis intervention; individual and family counseling; primary and preventive health services; substance abuse counseling; employment counseling, training, and placement; summer and part-time job development; recreation; and referrals to health and social services. SBYSP may provide other services, such as teen parenting programs, special vocational programs, hotlines and family planning. (While SBYSP projects may provide family planning services, SBYSP funds cannot be used to provide family planning services.) Students must have parental consent to use SBYSP services.

A SBYSP project is developed by a partnership among a school district, other local public agencies and private nonprofit organizations at the community level. The application for state funds is submitted jointly by the school district and at least one other nonprofit private or public entity. One agency serves as the managing agency responsible for program administration. Over half of the managing agencies are schools themselves, medical schools and hospitals, or mental health agencies. Among other entities serving as SBYSP managing agencies are a county health department, a city human resources department, an Urban League, a community development organization and a private industry council.

When selecting projects for funding, the New Jersey Department of Human Services looks for evidence that a broad coalition of local community groups, businesses and organizations, teachers, parents and public agencies support the project and participated in its development.

State funds serve as the core of support for SBYSP projects. In the first year of the program, six million dollars were available, and despite severe state budget problems, funding has been maintained. For FY 1993, the legislature appropriated seven and a half million dollars. State grants made to each project vary, up to a maximum of $250,000. These funds can be used for the costs of staff, services, materials and contractual arrangements with off-site providers of specialized services to which students are referred.

The community is responsible for providing at least one-quarter of its project's budget. The community can meet this match through in-kind contributions of facilities, services and materials, as well as through direct financial support.

To date, federal funds have not played a large role in supporting SBYSP health services. At the state level SBYSP staff are working to reduce barriers to obtaining Medicaid reimbursement, particularly seeking revision of state Medicaid licensure and facilities requirements so that SBYSP health services can qualify. Some of the projects may be tapping into federal support indirectly. For instance, community health centers have been involved in providing the health services component of some SBYSP projects. And in some SBYSP projects, family planning services are provided by staff from a local Planned Parenthood or other family planning clinic that receives Title X funds.

New Jersey's SBYSP is considered a model program. In 1990, the American Public Welfare Association gave the program its Successful Projects Initiative Award, and in 1991 it received the joint Innovations Award from the Ford Foundation and the Kennedy School of Government.

For more information about the New Jersey School Based Youth Services Program contact:

Roberta Knowlton, Director
School Based Youth Services Program
Office of Legal and Regulatory Affairs
New Jersey Department of Human Services
CN 700
222 S. Warren St.
Trenton, NJ 08625
(609) 292-7816

New Mexico

In New Mexico, the Maternal and Child Health Program has played a critical role in promoting SBHCs. Title V Block Grant funds provide a foundation of support for the state's SBHCs, to which other federal, state and local resources are added.[3]

Against a backdrop of limited access to health services, particularly severe in the state's rural areas, New Mexico's high rates of pregnancy and sexually transmitted disease among teenagers were the spur which led to the development of SBHCs in New Mexico, beginning in the mid-1980s. Dottie Montoya, a school nurse in Espanola, New Mexico, launched the first SBHC in New Mexico in 1984, in the school in which she worked; family planning services were among the services offered.

A few years later, in 1986, the New Mexico Maternal and Child Health Bureau established its Adolescent Health Program (AHP). In its search for health service delivery approaches that would be effective in meeting adolescents' health needs, AHP learned about the Espanola SBHC, and began to support it with Title V funds. AHP also began systematically fostering the development of the SBHC model throughout the state, promoting it in communities in which school-based health services could address existing health needs, and providing funds, training and technical assistance to support SBHCs.

AHP's work to foster the development of SBHCs in New Mexico got a boost in 1992, when the legislature appropriated over one and half million dollars for counties to develop and implement comprehensive health services plans. As part of this effort, each county set up a task force to assess the county's health service needs and develop a plan to meet them. Several county task forces included school-based health services in their plans.

As of 1993, 29 SBHCs were operating in New Mexico, 21 with support from AHP.[4] Each community designs its own program, within the context of guidelines issued by AHP. To receive support from the AHP, the SBHC must employ a mid-level health professional to provide the health services – a nurse, nurse practitioner or physician's assistant, who is supervised by a physician. If the school has a school nurse, she or he is involved as a link between the students and the SBHC. The school must actively participate in the planning of the SBHC; and the request for AHP support must come from the school, with a letter of support from the school superintendent.

Most of New Mexico's SBHCs do not provide comprehensive services. Each SBHC must provide certain basic services on-site, including gynecological and testicular exams, pregnancy testing, sexually transmitted disease screening and physical assessments. When treatment is needed that is not provided on-site, the SBHCs refer students to their primary care provider, who is identified when the child enrolls. When students have no primary care provider, the SBHC must either help them find one or refer them to a local public health department. The SBHCs are expected to develop a network of community and public health providers. SBHC enrollment must be made open to all students at the school.

Although preventing pregnancies among adolescents is one of the motivating reasons for establishing SBHCs in New Mexico, AHP does not require that the SBHCs it supports provide family planning services, a decision made to reduce community opposition. AHP supported clinics may provide family planning services, which about a quarter do.

The New Mexico Maternal and Child Health Bureau devotes a portion of its Title V block grant funds to the SBHCs. In FY 1993, 213 thousand dollars of Title V funds were allocated to the SBHCs. As states are required to match every four federal Title V dollars with three of their own, the 213 thousand dollars represents both state and federal support. The state uses this money to reimburse SBHCs for services provided by the mid-level practitioners who staff the SBHC, up to a maximum of $20,000 per SBHC. SBHCs which provide family planning services receive indirect support from Title X. Title X funds come from the federal government to the Family Planning Program in the New Mexico Maternal and Child Health Bureau. The state distributes the Title X funds to local public health departments, who have donated to SBHCs equipment, staff time and pharmaceuticals for the treatment of sexually transmitted diseases. Some additional indirect federal support also comes from the New Mexico Primary Care Unit, which uses federal grants and state funds to provide community health practitioners — physicians and mid-level practitioners — to communities that are medically underserved. In some cases the Primary Care Unit has provided SBHCs with a physician who supervises clinic staff.

Six Albuquerque SBHCs also receive support from the University of New Mexico's School of Medicine, in collaboration with the school district. The SBHCs serve as rotation sites for students and residents from the Departments of Family Medicine, Emergency Services, and Pediatrics. Medical students and residents provide general primary care and health education in the SBHCs. The Psychiatry Department also provides some on-site mental health services.

Through a special pilot project, some of New Mexico's SBHCs will begin billing Medicaid by the end of 1993. As part of a long-term strategy to enable all schools to bill Medicaid for services provided by school nurses or provided as part of special education for children with disabilities, eight schools have received Medicaid provider numbers. SBHCs are located at four of these schools, which will bill for services provided by the SBHCs. In addition, the school can bill as a Medicaid administrative cost the staff time spent in assisting students to establish Medicaid eligibility. All Medicaid funds received by the schools will be used to provide additional health services. This pilot project is the result of an extensive interagency collaboration among the New Mexico Departments of Education, Health, and Finance and the Medicaid unit. New Mexico had assistance from a private consultant, the Institute for Human Services Management, which has worked with other states to certify schools as Medicaid providers. It took about a year and half to work out the procedures and obtain the necessary federal waivers from the Health Care Financing Administration.

For more information about the New Mexico Adolescent Health Program and the school based health centers it supports contact:

Karen Gaylord
Bureau of Maternal and Child Health
New Mexico Department of Health and Environment
1190 St. Francis Drive
P.O. Box 968
Santa Fe, NM 87504
(505) 827-2356

California[5]

The first school-based health centers (SBHCs) in California were initiated in 1985 and 1986 in the San Francisco Bay area, followed by the establishment of SBHCs in Southern California. The development and implementation of these model programs reflects the infusion of private foundation support. Currently there are 25 school-based or school-linked health centers serving students attending a total of 64 schools.

Seventeen of the SBHCs reflect the traditional model of being physically located at a school site and serving only students enrolled in the one specific school. Among the 17, there are two sets of SBHCs located on campuses comprised of either an elementary and middle school or a middle and secondary school. The other eight centers reflect variations on the traditional model. For example, five of the SBHCs are physically located at a school, serve the children and adolescents attending that school, but also make their services available to other schools within several school districts. At several of these sites, services are also made available to adults and other family members, as well as siblings. One of the sites is located at a school district office site and serves students from all surrounding schools, transporting students to the SBHC through the use of a mini van. Another SBHC serves students from two high schools, with staff rotating through the schools during school hours, followed by appointments after school in a store front health clinic. One of the programs uses a mobile van that serves schools, with the van available at each site one designated day per week.

The SBHCs employ a multi-faceted approach to child and adolescent health care that addresses primary health needs such as medical screening and treatment for minor and chronic illness and injury, as well as mental health issues, substance abuse, adolescent sexuality, unintended pregnancy, sexually transmitted diseases and preventive health care practices. As each of the SBHCs has different sponsoring agencies, including health departments, hospitals, schools, community-based health centers and Federally Qualified Health Centers (FQHCs), SBHCs have developed a mosaic of funding streams to help sustain their efforts over time. The complexity of the categorical programs, the different eligibility issues associated with each funding stream, as well as the SBHCs' struggle to gain credibility and acceptance as a part of the existing health care delivery arena have all contributed to the difficulties that SBHCs have encountered in sustaining their activities.

SBHCs have shown great creativity in and commitment to finding solutions, as well as great savvy regarding the use of community in-kind support from myriad health and social programs operating in the community and/or co-located on-site in the health centers. Nevertheless, it has been a major challenge for SBHCs to maintain their financial viability.

The financial streams used to support SBHCs in California are somewhat parallel between sites operating for about the same length of time. In their initial phase of operation, SBHCs largely depended on national, state and local private foundations for the primary source of funding, representing between 40 percent and 75 percent of the overall SBHC budget. After approximately six years of operation, foundation money generally decreased to 20 percent of operating expenses or, in some sites, was completely eliminated.

Initially, foundations provided financial support for the SBHCs' general operating costs. More recently, foundation support has been earmarked for specific activities such as research projects, hiring of special consultants to assist SBHCs in developing billing capacity, and special reproductive health services and health education efforts. Initially, SBHCs and foundations anticipated that following the successful implementation of programs, direct state and federal support would become available to sustain the programs. Due to a number of factors, however, including poor economic conditions in California, a new state focus on funding school-linked services which does not necessarily fund the provision of health services directly on campus, and the limited opportunity of SBHCs singly or collaboratively to advocate for themselves, SBHCs are seeking to sustain their efforts by establishing billing mechanisms that tap existing state and federal programs.

Reimbursement for medical care from Medicaid, the largest medical source of funding, is still relatively low. Currently most Medicaid reimbursements reflect support for the provision of "sensitive services" under a special component of California's Medicaid program. Under this unique program, enrolled students can receive mental health counseling, pregnancy and family planning services, diagnosis and treatment for sexually transmitted diseases, sexual and physical abuse services and drug and alcohol abuse counseling. Traditionally, eligibility for Medicaid is linked to family income. However, under the auspices of California's Medicaid Minor Consent Service program, adolescents' eligibility is not dependent on family income and thus enrollment is greatly simplified. The program allows adolescents to receive these services confidentially without requiring parental consent or payment.

Medicaid reimbursement for these services is provided fully from state funds and does not reflect the traditional 50 percent federal and 50 percent state match. The state cannot claim reimbursement from the federal government because the program provides benefits beyond those covered under the federal Medicaid program.

At one SBHC nearly 95 percent of the money received from Medicaid has been generated as a result of the provision of sensitive services. Many SBHCs, however, cannot take full advantage of this program. Centers with a Medicaid health license rather than a Medicaid psychiatric license will only be reimbursed for outpatient mental health services provided by physicians, board certified psychiatrists and licensed clinical psychologists. Under these restrictions, California will not reimburse the SBHCs for mental health services provided by a licensed clinical social worker or a marriage, family, and child counselor, who are frequently the providers of SBHC mental health services.[6]

As between 20 percent and 35 percent of the school populations are Medicaid eligible, this funding stream has been identified as a viable source of money for general medical care, as well as for the provision of special services such as mental health services. However, SBHCs still face the dilemma of how they will be reimbursed for providing treatment for students who are not eligible for the Medicaid program. A further complicating factor is that a significant proportion of this population is comprised of undocumented immigrants who are not eligible to receive care through the Medicaid program (with the exception of women who are pregnant), although they are able to enroll in school.

A number of other financial resources have been utilized by some of the health centers. It is important to note that access to these resources is limited and may depend on the type of agency sponsoring the SBHC, the success of some SBHCs in some counties to negotiate for their inclusion in the funding option and the levels of funding available, which may be insufficient to cover all eligible students. Although these funding streams represent an important resource to SBHCs, they only partially support health center services, representing only 25 percent to 30 percent of overall resources even among those SBHCs that are eligible to receive funds. Some financial resources accessed include:

- The California Health and Disability Program (CHDP), California's equivalent to the national Early Periodic Screening, Diagnosis and Treatment Program (EPSDT), provides physical exams to children from birth to 21 years old on Medicaid or to children living within 200 percent of poverty.
- Proposition 99, a special state law that placed a $.25 tax on each pack of cigarettes sold in the state, has generated funds that support three different programs including 1) special school-wide health education focusing on the prevention of tobacco use, 2) Early Access to Primary Care (EAPC) which provides primary and acute care to medically under-served children, and 3) California Health for Indigent Populations (CHIP) which provides pediatric and emergency/trauma services for medically indigent children who because of eligibility requirements are not covered by other entitlement programs.
- California's Office of Family Planning (OFP) funds two complementary programs. One supports reproductive clinical services including contraceptive methods, pregnancy testing, counseling, education, health examinations, STD treatment and HIV screening. The other provides funds to support information projects that focus on the need for nine to 18 year olds to make responsible decisions regarding their sexuality and reproductive health. This program also offers information on community resources and provides adolescents with skills regarding responsible contraceptive use.[7]

To broaden the services available on-site, California's SBHCs have collaborated with community agencies that provide in-kind services directly on-site. Though the combination and particular services provided vary from site to site, the following are some examples of the cooperative efforts: community mental health agencies co-locate counselors on-site; community agencies provide on-site drug and alcohol counselors; and health departments, school districts, and other community based organizations contribute partial salary support for staff and/or equipment.

The SBHCs are at different stages of billing for services provided, but all are moving in the direction of third party billing. Most agree that there is great potential for increasing revenues through billing Medicaid, Medicaid Minor Consent Services, and CHDP. To better facilitate reimbursement for sensitive services, SBHCs have tried to simplify the enrollment process for their students. A number of the SBHCs have a Medicaid eligibility worker periodically located on-site who assists adolescents with their enrollment in the Medicaid Minor Consent Services Program. A few SBHCs have negotiated a special agreement with their respective Department of Social Services that "deputized" the SBHC to help students complete the enrollment application. All necessary paperwork required for the application process is conducted on-site and sent to the Department of Social Services for processing. This helps to overcome a major barrier to care for adolescents and allows SBHCs to seek reimbursement for services they already provide to their clients.

Another tactic some California SBHCs have used to increase revenue is to hire a billing clerk or contract with an agency whose expertise is billing. In the latter case, the costs associated with the billing service are weighed against the level of funding that is generated. The process of billing may also be facilitated by a billing component being designed for the ON LINE Management Information System (MIS) used at many of the SBHCs. Dr. David Kaplan, Professor of Pediatrics at the University of Colorado (Denver) School of Medicine and the developer of the ON LINE system, is currently developing a billing component for the system which will most likely be ready in the spring of 1994. This MIS is used extensively throughout the country and, with specific adaptations for the unique billing channels available in each state, it is anticipated that this component will be helpful to many SBHCs.

Funding for this project was provided by a special, one-time, state legislative fund that was passed as a result of intense advocacy by SBHCs for mechanisms to generate billing. Through this fund, a number of SBHCs also received a small amount of money to buy computers and software, as well as to provide some initial support for billing staff. It is anticipated that with the ability of SBHCs to tap into existing funding streams, a larger portion, but not all, of the funds required to operate the SBHCs will be generated. Foundation support will continue to play a role in developing and sustaining special service components, for example, programs aimed at reducing adolescent pregnancy identifying additional funding mechanisms to sustain their operations.

As the SBHCs struggle for financial stability, each is working very hard to identify potential sources of funding and develop strategies to generate revenue and decrease their dependence on foundation support. The majority of SBHCs seem to be focusing energy on the billing of third party payers. Many are hopeful that they will be able to increase the number of physical exams provided through the SBHC and receive CHDP reimbursement for those services.

Some SBHCs are also looking towards recruiting corporate sponsors in the community for funds or in-kind support to sustain the SBHCs. Several of the sites have been able to receive relatively small, but important, contributions from local businesses on a periodic basis. For example, several businesses have provided funds to buy health education materials and supplies for the SBHCs, while others have donated office and clinical equipment.

Other potential sources of funding are new state supported programs. Healthy Start, developed as part of the Governor's initiative for prevention and early intervention programs for children and supported by the state legislature, authorizes the Superintendent of Public Institutions to award annual planning and operational grants to school districts or county offices of education to provide school-based or school-linked integrated health, mental health, social and other support services for children and their families. The program was funded at $20 million in FY 1992 and $13 million in FY 1993. Sixty-five school districts throughout the state have initiated programs, with the majority serving elementary school students. Of these new Healthy Start programs, only five of the schools have operating SBHCs. While these grants have helped to enhance the range of services provided by SBHCs — for example, by adding mental health and case management components — only a small portion of the Healthy Start funds awarded have helped to offset SBHC core operating expenses.

Through Healthy Start, California has received permission for the school to bill Medicaid for health related services delivered on campus to Medicaid eligible students. Reimbursable services range from expenses related to speech therapists and school psychologists, to the provision of screening assessments and referrals conducted by school personnel. Reimbursement will, however, be at a lower rate than the one allowed for SBHCs, as the reimbursement generated by schools is only for the federal share of costs which up to now have not been allowed to be claimed by the schools.

Traditionally, under the Medicaid program, states and the federal government provide matching funds to reimburse for health services provided by an outside health agency. In Healthy Start, the state now pays for its share of the costs associated with providing care for students at the school site. A Local Education Agency (LEA) Medicaid Billing Option enables schools to claim additional funds from the federal government by billing Medicaid for covered health and social services offered in the school setting.[8] The funds generated will be returned to the LEAs for the purpose of expanding health and human services for children and their families. Initial implementation of this new program will occur in a limited number of pilot sites before wide replication occurs. At the current time, it is unknown how many of these funds will be used to actually offset SBHC core operating expenses.

Funds for Targeted Case Management were made possible by state legislation that allows county health departments to bill for the provision of case management services to special categories of Medicaid eligible populations, including youth in high risk situations, pregnant, postpartum and parenting young women, and persons abusing alcohol, drugs or both. In order to qualify for funds, SBHCs must have qualified staff to provide the services and conduct time studies to document how staff devote their time.[9]

There are, however, limitations to this source of funding. One limitation is that only public health departments — and therefore only those SBHCs sponsored by public health departments — will have access to these funds. Another limitation is the single focus on traditional health services. A case manager will not be able to bill for time spent responding to non-medical needs such as education, family or vocational problems which also impact the health status of adolescents. It is anticipated that as this program becomes established, other health entities will advocate to become eligible sponsoring agencies for Targeted Case Management funds, thus allowing other SBHCs access to funds for overall coordination of care.

Another important factor in the changing fiscal landscape of California's SBHCs is the impact on the SBHCs of the state's plan to establish a system of managed care for Medicaid recipients. A number of important policy decisions will need to be made regarding the role of SBHCs within a managed care system, including whether or not SBHCs should be included as potential satellites of existing or new managed care providers, whether they should remain independent and accept a number of different subcontract arrangements with managed care providers in the community and how to fund services for students who may not be enrolled in a managed care system.

As shown in this overview, each SBHC is seeking creative ways to tap into existing and potential sources of funding. As health care reform initiatives move forward, the SBHCs will be actively involved in advocacy in order to ensure their ability to sustain the array of services they provide to young people.

Conclusion

Traditionally, SBHCs have obtained a relatively small proportion of their support from federal funding sources. The federal support that has been available to SBHCs has come primarily from the Maternal and Child Health Services Block Grant.

On paper at least, there are a number of other possible sources of federal support. Other health-related block grants and the Drug-Free Schools and Communities State Grants can be used to fund the types of care which SBHCs so often provide — preventive care, and mental health and substance abuse services. Medicaid represents a huge amount of money, and changes in the Medicaid program — the increasing coverage of children solely on the basis of their poverty status and the expansion of the EPSDT component — may well make it cost-effective for SBHCs to put in the time and effort to overcome the barriers which have kept them from receiving reimbursement for Medicaid-covered services. Federal funds also support potential collaborators for SBHCs — community health centers, family planning clincs and community-based mental health service providers — through whom federal support may be obtained indirectly.

But to tap into many of these funds SBHCs will have to compete with the traditional recipients of these funds, who in these tight money times may not be very pleased to see new claimants to "their" federal funding sources. SBHCs will need to be the best advocates on their own behalf that they can possibly be. SBHCs can enhance the likelihood of success by joining together to share information and to collectively articulate the needs of SBHCs and their effectiveness in delivering needed services to young people.

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[1] Information about the New Jersey School Based Youth Services Program was obtained from contacts with program staff and from various written materials supplied by the program. Caroline Reynolds, an intern at the Center for Population Options in summer, 1992, assisted with the research.

[2] See, for instance, document entitled *Questions Frequently Asked About the School Based Youth Services Program,* (undated), available from the New Jersey School Based Youth Services Program.

[3] Information about New Mexico's Adolescent Health Program and its SBHCs was obtained from staff at the New Mexico Maternal and Child Health Program and from *Opportunities for Enhancing Preventive and Primary Care Through School-Based Health Centers: Three States' Title V Program Experiences,* Association of Maternal and Child Health Programs February, 1993. Caroline Reynolds assisted with the research.

[4] The remaining eight are supported by private foundations and the United States Indian Health Service (IHS). The Indian Health Service is in the Public Health Service of the United States Deparartment of Health and Human Services. SBHCs with high enrollments of Native American Students should consider contacting the IHS.

[5] This section on financing of SBHCs in California was researched and written by Claire Brindis, DrPH, and Amy Wolfe, MPH, Institute for Health Policy Studies, School of Medicine, University of California, San Fransisco. It is based on answers by the directors of a sample of California's SBHCs to questions about their sources of funding, the services supported by specific funds and their vision of future financing options.

[6] An exception to this provision is made for FQHCs, such as the federally funded community health services. Federal law authorizes FQHCs to bill Medicaid for mental health services provided by a much broader array of professionals. Only a few SBHCs in California are sponsored by FQHCs.

[7] Governor Pete Wilson's Teen Pregnancy Prevention Initiative of 1991 augmented existing OFP programs by providing expanded teen counseling, clinical services, and the Education Now and Babies Later (ENABL) health education campaign which helps 12-14 year olds learn and practice the skills they need to postpone sexual involvement.

[8] For example, LEAs now providing therapy services to Special Education students as required by their Individualized Education Plan (IEP) can bill Medicaid for these health related services. Other services will include health and mental health evaluation, counseling, psychology services, nursing and school health aide services, and medical transportation services.

[9] One SBHC is receiving support from a private foundation to hire the necessary staff and conduct the time studies required to qualify for these funds. It is anticipated that the revenue generated by this professional will be sufficient to sustain the position.

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RESOURCES

Information about all federal assistance programs can be found in the Catalog of Federal Domestic Assistance, published every year in June, with updates in December, by the U.S. Office of Management and Budget, and General Services Administration. Statutes authorizing federal assistance programs are found in the United States Code, cited as: Title # U.S.C. Section #. Regulations implementing these programs are found in the Code of Federal Regulations, cited as: Title # C.F.R. Part #. Notices of the availability of grant funds are published in the daily Federal Register, which are cited as Volume # Fed. Reg. Page # (Date). Grant application kits also contain detailed information about program requirements.

Other resources consulted in preparing this report include:

EPSDT: A Guide for Educational Programs. U.S. Department of Health and Human Services. Health Care Financing Administration. Medicaid Bureau (September. 1992).

"Financing Health Services in School-Based Clinics: Do Nontraditional Programs Tap Traditional Funding Sources?" Judith Palfrey. Martha McGaughey. Paula Cooperman. Terrence Fenton and Margaret McManus. in *Journal of Adolescent Health*. Vol. 12. May. 1991. pp. 231-239

1992 Green Book: Overview of Entitlement Programs: Background Material and Data on Programs Within the Jurisdiction of the *Committee on Ways and Means*. U.S. House of Representatives. Committee on Ways and Means. 102nd Congress. 2nd Session (May 15. 1992).

HCFA Fact Sheet: Medicaid. U.S. Department of Health and Human Services. Health Care Financing Administration. Medicaid Bureau (January. 1992).

HCFA Fact Sheet: Medicaid and Maternal and Infant Health. U.S. Department of Health and Human Services. Health Care Financing Administration. Medicaid Bureau (July. 1992).

HCFA Fact Sheet: Medicaid Coordinated Care Programs. U.S. Department of Health and Human Services. Health Care Financing Administration. Medicaid Bureau (July. 1992).

HCFA Fact Sheet: Medicaid's Child Health Program. U.S. Department of Health and Human Services. Health Care Financing Administration. Medicaid Bureau (July. 1992).

Healthy Schools: A Directory of Federal Programs and Activities *Related to Health Promotion Through the Schools*. U.S. Department of Health and Human Services. Federal Interagency Ad Hoc Committee on Health Promotion Through the Schools (1992).

Medicaid: MCH Related Federal Programs: Legal Handbooks for *Program Planners*. Association of Maternal and Child Health Programs (Washington DC: December. 1990).

Memorandum to Adolescent Health Coordinators and Title V *Directors Re- Financing Technical Assistance*. Paul Newacheck. Peggy McManus and Harriette Fox (Institute for Health Policy Studies. University of California. San Francisco: Summer. 1991).

Opportunities for Enhancing Preventive and Primary Care Through School-Based Health Centers: Three States' Title V Program *Experiences*. Association of Maternal and Child Health Programs. (Washington. DC: February. 1993).

The Role of Title V Maternal and Child Health Programs In *Assuring Access to Health Services for Adolescents*

ABOUT THE AUTHOR

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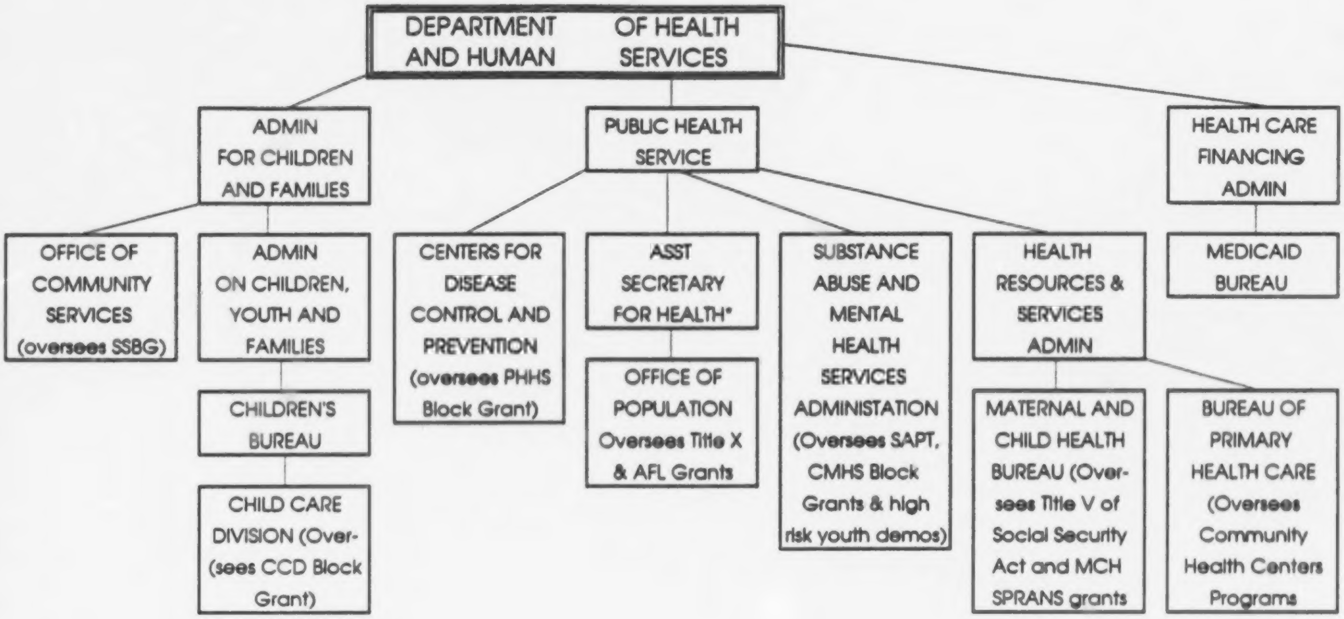
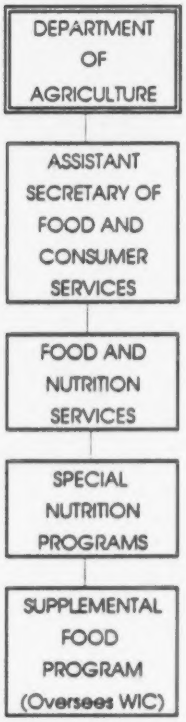
APPENDIX A

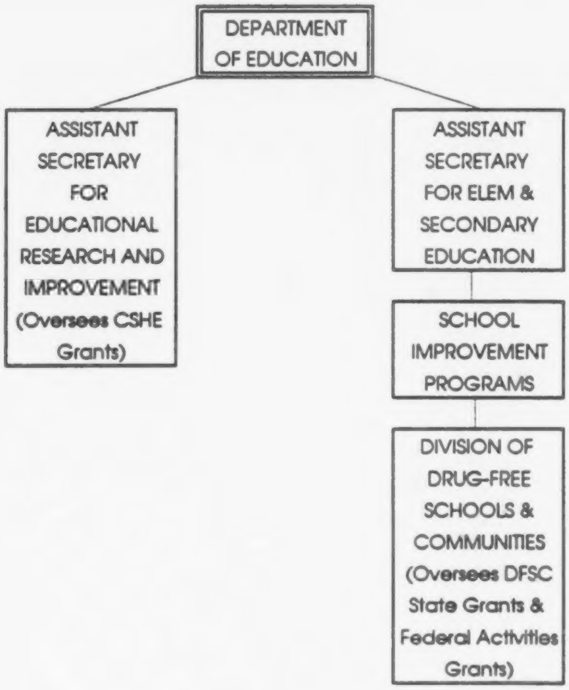
List of Acronyms

ADMS Alcohol and Drug Abuse and Mental Health Services Block Grant
AFDC Aid to Families with Dependent Children
AFL Adolescent Family Life Demonstration Grant
AHP New Mexico's Adolescent Health Program
CCD Child Care and Development Block Grant
CFR Code of Federal Regulations
CHDP California Health and Disability Program
CHIP California Health for Indigent Populations
CMHS Community Mental Health Services Block Grant
CSAP Center for Substance Abuse Prevention
CSHE Comprehensive School Health Education
CSHN Children with Special Health Needs
DARE Drug Abuse Resistance Education
DFSC Drug-Free Schools and Communities
DSM-III-R Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association)
EAPC Early Access to Primary Care
ENABL Education Now and Babies Later
EPSDT Early and Periodic Screening, Diagnosis and Treatment
FFP Federal Financial Participation
FQHC Federally Qualified Health Center
HRSA Health Resources and Services Administration
HTPC Healthy Tomorrows Partnerships for Children
IEP Individualized Education Plan
LEA Local Education Agency
MCH Maternal and Child Health
MIS Management Information System
OFP Office of Family Planning
PHHS Public Health and Health Services Block Grant
SAPT Substance Abuse Prevention and Treatment Block Grant
SBHC School-based or School-linked Health Center
SBYSP New Jersey School Based Youth Services Program
SPRANS Special Projects of Regional and National Significance
SSI Supplemental Security Income
USC United States Code
WIC Supplemental Food Program for Women, Infants, and Children

APPENDIX B: FEDERAL AGENCIES WITH RESPONSIBILITY FOR ADOLESCENT SERVICES


DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMIN FOR CHILDREN AND FAMILIES
PUBLIC HEALTH SERVICE
HEALTH CARE FINANCING ADMIN
OFFICE OF COMMUNITY SERVICES (oversees SSBG)
ADMIN ON CHILDREN, YOUTH AND FAMILIES
CHILDREN'S BUREAU
CHILD CARE DIVISION (Oversees CCD Block Grant)
CENTERS FOR DISEASE CONTROL AND PREVENTION (oversees PHHS Block Grant)
ASST SECRETARY FOR HEALTH*
OFFICE OF POPULATION Oversees Title X & AFL Grants
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTATION (Oversees SAPT, CMHS Block Grants & high risk youth demos)
HEALTH RESOURCES & SERVICES ADMIN
MATERNAL AND CHILD HEALTH BUREAU (Oversees Title V of Social Security Act and MCH SPRANS grants
BUREAU OF PRIMARY HEALTH CARE (Oversees Community Health Centers Programs
MEDICAID BUREAU


DEPARTMENT OF AGRICULTURE
ASSISTANT SECRETARY OF FOOD AND CONSUMER SERVICES
FOOD AND NUTRITION SERVICES
SPECIAL NUTRITION PROGRAMS
SUPPLEMENTAL FOOD PROGRAM (Oversees WIC)


DEPARTMENT OF EDUCATION
ASSISTANT SECRETARY FOR EDUCATIONAL RESEARCH AND IMPROVEMENT (Oversees CSHE Grants)
ASSISTANT SECRETARY FOR ELEM & SECONDARY EDUCATION
SCHOOL IMPROVEMENT PROGRAMS
DIVISION OF DRUG-FREE SCHOOLS & COMMUNITIES (Oversees DFSC State Grants & Federal Activities Grants)

APPENDIX C: Medicaid Federal Financial Participation Rates by State

Listed below are the percentages of allowable costs which are reimbursed to the states by the federal Medicaid program.

State	FederalPercent
Alabama	71.22
Alaska	50.00
American Samoa	50.00
Arizona	65.90
Arkansas	74.46
California	50.00
Colorado	54.30
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	54.78
Georgia	62.47
Guam	50.00
Hawaii	50.00
Idaho	70.92
Illinois	50.00
Indiana	63.49
Iowa	63.33
Kansas	59.52
Kentucky	70.91
Louisiana	73.49
Maine	61.96
Maryland	50.00
Massachusetts	50.00
Michigan	56.37
Minnesota	54.65
Mississippi	78.85
Missouri	60.64
Montana	71.05
Nebraska	61.98
Nevada	50.31
New Hampshire	50.00
New Jersey	50.00
New Mexico	74.17
New York	50.00
North Carolina	65.14
North Dakota	71.13
Northern Mariana Islands	50.00
Ohio	60.83
Oklahoma	70.39
Oregon	62.12
Pennsylvania	54.61
Puerto Rico	50.00
Rhode Island	53.87

South Carolina	71.08
South Dakota	69.50
Tennessee	67.15
Texas	64.18
Utah	74.35
Vermont	59.55
Virgin Islands	50.00
Virginia	50.00
Washington	54.24
West Virginia	75.72
Wisconsin	60.47
Wyoming	65.63

This information was provided by the Medicaid Bureau. It is published annually in the *Federal Register*.

(effective Oct 1, 1993 - Sept 30, 1994)

APPENDIX D: State Contacts for Selected Federal Programs

Appendix A lists state contacts for the grants and programs discussed in this guide. This list was compiled by Carrie A. Meyerhoff, with assistance from Marge Mazie and Rocio Leonzo. Names were obtained from the federal government and were verified in June and July of 1993. Names which we were unable to verify are noted with a double asterisk (**). We were unable to obtain a list of contacts for the Social Services Block Grant and have done our best to compile one.

In some instances, we were told that there is no single contact person for a given grant. In other cases, the Director is listed as the contact, but he or she might delegate the call to someone else. Therefore, you may be transferred to another person once you have explained the nature of your query. Also, you may be given the name and phone number of a contact at the county level. Do not be discouraged if you are transferred or need to make more than one call.

Some states have individuals devoted specifically to adolescent health. A list of these individuals is included at the back of this appendix. There may also be special state-funded initiatives aimed at adolescent health concerns, such as drug prevention programs. Be sure to ask about other sources of funding or other programs in which you may be able to participate.

Good luck on your quest to find funding for your school-based health center. Any successes are major, because they will bring you closer to providing much-needed health services to our young people.

Section 1: Title V: Maternal and Child Health (MCH)Services Block Grant 72
  Title V: Children With Special Health Needs Contacts 78
Section 2: Preventive Health and Health Services Block Grant Contacts 82
Section 3: Substance Abuse Prevention and Treatment Block Grant Contacts 86
Section 4: Community Mental Health Services Block Grant Contacts 91
Section 5: Medicaid/EPSDT Contacts 95
Section 6: Drug-Free Schools and Communities--State Grants Contacts 100
  Governor's Office 100
  State Education Agency 104
Section 7: Title X: Grants for Family Planning Services Contacts 109
Section 8: WIC Program Contacts 114
Section 9: Social Services Block Grant Contacts 120
Section 10: Child Care and Development Block Grant Contacts 124
Section 11: State Adolescent Health Contacts 128

Section 1: MCH Contacts

Alabama
Tom M. Miller, MD, MPH, FACOG
Acting Director
Bureau of Family Health Services
AL Dept. of Public Health
434 Monroe St., 4th Floor
Montgomery, AL 36130-1701
(205) 242-5661
FAX (205) 269-4865

Alaska
Karen Pearson, RD, MS
Section Chief
Section of Maternal, Child and Family Health
AK Dept. of Health and Social Services
1231 Gambell St., Room 311
Anchorage, AK 99501-4627
(907) 274-7626
FAX (907) 586-1877

American Samoa
**Matt Tunoa, Director
Department of Health
Pago Pago, AS 96799
(684) 633-1222

**Diana Tuinei, RN, MPH[1]
MCH Coordinator
Government of American Samoa
Department of Health Service
LBJ Tropical Medical Center
Pago Pago, AS 96799
(684) 633-4606

Arizona
Jane Pearson, RN
Office Chief
Office of Women's and Children's Health
Div. of Family Health Services
AZ Dept. of Health Services
1740 West Adams, Room 200
Phoenix, AZ 85007
(602) 542-1870
FAX (602) 542-2789

Arkansas
Richard Nugent, MD, MPH
Medical Director
Section of MCH
Arkansas Dept. of Health
4815 West Markham, Slot #41
Little Rock, AR 72205
(501) 661- 2199
FAX (501) 661-2055

California
Stephen W. Kessler
Deputy Director
Primary Care and Family Health
CA State Dept. of Health Services
714 P Street, Room 450
Sacramento, CA 95814
(916) 654-0265
FAX (916) 657-0796

Rugmini Shah, MD
Chief
MCH Branch
CA State Dept. of Health Services
714 P Street, Room 750
Sacramento, CA 95814
(916) 657-1347
FAX (916) 657-0796

Colorado
Daniel Gossert, ACSW, MPH
Director
Family and Community Health Services
Division
CO Dept. of Health
4300 Cherry Creek Drive South
Denver, CO 80222
(303) 692-2315
FAX (303) 782-5576

Connecticut
Suzette Benn, RN, MPA
Acting Bureau Chief
Bureau of Community Health Services
State Dept. of Health Services
150 Washington Street
Hartford, CT 06106
(203) 566-4282
FAX (203) 566-8401

John Huttner
Maternal and Infant Health Division
Bureau of Community Health
150 Washington Street
Hartford, CT 06106
(203) 566-5601
FAX (203) 566-8401

Delaware
Sathyavathi Lingaraju, MD, MPH
Director
MCH Service
Division of Public Health
P.O. Box 637
Dover, DE 19903
(302) 739-4785
FAX (302) 739-6617

District of Columbia
Patricia Tompkins, MS, RN
Chief
Office of MCH
Commission of Public Health
Suite 907
1660 L Street, NW
Washington, DC 20036
(202) 673-4551
FAX (202) 727-9021

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[1] Also listed as PHHS Block Grant contact.

[2] Also listed as PHHS Block Grant contact.

[3] Also listed as WIC contact.

[4] Also listed as SSBG contact.

[5] Also listed as Title X contact.

[6] Also listed as PHHS Block Grant contact.

[7] Also listed as PHHS Block Grant contact.

[8] Also listed as State Adolescent Health contact.

[9] Also listed as PHHS Block Grant contact and SAPT Block Grant contact.

[10] Also listed as State Adolescent Health contact.

[11] Also listed as State Adolescent Health contact.

[12] Also listed as State Adolescent Health contact.

[13] Also listed as PHHS Block Grant contact.

[14] Also listed as Medicaid contact.

[15] Also listed as Title V contact.

[16] Also listed as Title V contact.

[17] The contact for Maryland preferred to not have a specific name listed.

[18] Also listed as Title V contact.

[19] Also listed as Title V contact.

[20] Also listed as Title V contact and SAPT Block Grant contact.

[21] Also listed as SAPT Block Grant contact.

[22] Also listed as Title V contact.

[23] Also listed as DFSC (Governor's portion) contact.

[24] Also listed as CMHS Block Grant contact.

[25] Also listed as CMHS Block Grant contact.

[26] Also listed as DFSC (Governor's portion) contact.

[27] Also listed as DFSC (Governor's portion) contact.

[28] Also listed as DFSC (Governor's portion) contact.

[29] Also listed as DFSC (Governor's portion) contact.

[30] Also listed as PHHS Block Grant contact and Title V contact.

[31] Also listed as DSFC (Governor's portion) contact.

[32] Also listed as DFSC (Governor's portion) contact.

[33] Also listed as PHHS Block Grant contact.

[34] Also listed as DFSC (Governor's portion) contact.

[35] Also listed as SAPT Block Grant contact.

[36] Also listed as SAPT Block Grant contact.

[37] Also listed as SSBG contact.

[38] Also listed as Title V contact.

[39] Also listed as SAPT Block Grant contact.

[40] Also listed as SAPT Block Grant contact.

[41] Also listed as SAPT Block Grant contact.

[42] Also listed as SAPT Block Grant contact.

[43] Also listed as SAPT Block Grant contact.

[44] Also listed as SAPT Block Grant contact.

[45] Also listed as SAPT Block Grant contact.

[46] Also listed as SAPT Block Grant contact.

[47] The names listed here are the Title X Family Planning Grantees. You may also want to contact your local community Title X service provider.

[48] Also listed as Title V contact.

[49] Also listed as Title V contact.

[50] Also listed as CCD Block Grant contact.

[51] Also listed as CCD Block Grant contact.

[52] Also listed as CCD Block Grant contact.

[53] Also listed as CMHS Block Grant contact.

[54] Also listed as Title V contact.

[55] Also listed as CCD Block Grant contact.

[56] Maryland uses its Federal block grant funds as a revenue stream to fund its state social services programs. It does not distribute the block grant to different programs or nonprofits and does not entertain applications at the time of this writing.

[57] Also listed as CCD Block Grant contact.

[58] Also listed as SSBG contact.

[59] Also listed as SSBG contact.

[60] Also listed as SSBG contact.

[61] Also listed as SSBG contact.

[62] Also listed as SSBG contact.

[63] The names on this list were not confirmed. The list was dated 4/93.

[64] Also listed as Title V contact.

[65] Also listed as Title V contact.

[66] Also listed as Title V contact.

[67] Also listed as Title V contact.

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